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DELIVERY SYSTEM REFORM: PROGRESS REPORT FROM CMS

HEARING BEFORE THE COMMITTEE ON FINANCE UNITED STATES SENATE ONE HUNDRED THIRTEENTH CONGRESS FIRST SESSION

FEBRUARY 28, 2013



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DELIVERY SYSTEM REFORM: PROGRESS REPORT FROM CMS

THURSDAY, FEBRUARY 28, 2013

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:40 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Wyden, Stabenow, Cantwell, Nelson, Carper, Cardin, Brown, Bennet, Casey, Hatch, Grassley, Enzi, Thune, and Burr.

Also present: Democratic Staff: Mac Campbell, General Counsel; David Schwartz, Chief Health Counsel; Tony Clapsis, Professional Staff Member; Karen Fisher, Professional Staff Member; and Matt Kazan, Professional Staff Member. Republican Staff: Chris Campbell, Staff Director; Stephanie Carlton, Health Policy Advisor; and Kristin Welsh, Health Policy Advisor.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

President Abraham Lincoln once said, “The best way to predict your future is to create it.” In 2009, we did not like the future we saw for a health care system based on a fee-for-service payment model.

Doctors and hospitals were getting paid for the amount of care delivered instead of how well they delivered care to patients. So, with the Affordable Care Act, we created new and better ways to deliver health care, save taxpayers dollars, and improve patient care.

Medicare and Medicaid, in partnership with the private sector, are now working to create the road map for the future of health care delivery, and we are here today to make sure they are on the right track. There is a clear slow-down in health care spending, but we need to do more and to do it faster to change the way Medicare and Medicaid pay for health care.

At a hearing we held Tuesday on how to boost the country’s economic outlook, we learned from leading economists Douglas Holtz-Eakin and Bob Greenstein that the number-one way to reduce health care spending is to end fee-for-service. Everyone agrees that fee-for-service drives volume, excesses, and waste.

We know this way of paying for health care encourages the wrong things, and that is why health care reform changed incen-

tives for providers. Medicare and Medicaid are testing different programs to determine which work best.

In October, Medicare rolled out a program with a simple yet revolutionary premise: Medicare is going to pay hospitals to get the job done right the first time. Hospitals are penalized if patients are readmitted too soon after being discharged. Communities from Montana to Maryland are rising to the challenge. In Missoula, MT, the local Aging Services Agency is partnering with Medicare on care transitions.

Under this program, patients at high risk for readmissions to one of the two local hospitals in Missoula will get extra help making the transition from the hospital back to the community. Today we will hear about new data showing a significant first step in bending the curve on Medicare hospital readmissions.

The rate for Medicare patients returning to the hospital for treatment has fallen by more than a full percent over the past several months after being firmly stuck for years or decades. Medicare and Medicaid also implemented a new program in October that pays hospitals more for delivering better care and penalizes them financially for poor outcomes.

For those outside of health care, this idea will not sound revolutionary. It makes sense that when you take a car to the repair shop to get the brakes fixed and they break the windshield, you should not have to pay for the broken windshield.

Starting in October, hospitals can be penalized if you go in with a heart attack and the hospital is responsible for giving you a surgical infection. Hospitals can be rewarded for good customer service and patient care.

That means doctors and nurses share information and tests, explain medications, and develop a plan of coordinated care for a patient leaving the hospital. We need to get more value out of each taxpayer dollar spent. We also need to help providers work better together and coordinate care.

Medicare and Medicaid need to reimburse hospitals, doctors, and nursing homes to keep patients healthy. Accountable Care Organizations are starting to make this happen. Almost 300 Accountable Care Organizations, including in Billings, MT, have teamed up to serve more than 4 million beneficiaries.

In these organizations, doctors, hospitals, and other providers work together to give patients coordinated care. The providers make talking to each other a priority, and they work to ensure patients get the right care at the right time.

Medicaid has also come to the table to provide new solutions to the cost challenges facing States. Medicaid beneficiaries in Minnesota will be among the first to participate in a new integrated care model that will link patient outcomes and experience to payments. Providers will be held accountable by sharing in the savings and losses for the total cost of care.

My State of Montana started a program to lower diabetes and cardiovascular disease in its Medicaid population. The goal is to help participants lose weight and keep it off, which makes them healthier and reduces costs in the Medicaid program. We need Medicare and Medicaid to support these State efforts and offer flexibility to test innovative ideas.

I look forward to examining the progress Medicare and Medicaid have made, learning what has worked, and finding out where we can do more. So let us listen to President Lincoln and realize that we are in charge of creating our future. Let us do more to lower costs and improve quality within Medicare and Medicaid and create the future of health care delivery.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch?

**OPENING STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH**

Senator HATCH. Well, thank you, Mr. Chairman. Thank you for convening this timely and much-needed hearing this morning.

Now, last week *Time* magazine ran a thought-provoking article that was in fact the longest article in the publication's history. It was an exploration of the high costs of medical care in this country and what these costs mean for patients. It was a fascinating article, and it got me thinking.

Over the last 5 years, we have spent a lot of time here in Congress talking about health care. Obamacare was signed into law nearly 3 years ago and was supposed to make health care more affordable for patients and consumers.

Now, the so-called Affordable Care Act did a lot of things, but as far as I can tell it has done very little to address the biggest health-related concern that people have: the actual cost of care. I hope that at some point we can take a serious look at the drivers of health care costs in the U.S. I think it would be well worth the committee's time to do so.

Today, however, we are here for a different reason. The Finance Committee held a hearing last year where we heard from providers and third-party payers in the private sector who have come together to do some interesting things to try to improve care while reducing costs.

While I believe the private sector can and will make great strides in this area, we cannot forget that Medicare is the Nation's largest health care payer. That being the case, if we are serious about reducing costs, our efforts to encourage innovation must include Medicare. Now, I have been very clear about my opposition to Obamacare. My concerns about the adverse impact of this law on family premiums and our national health spending continue to grow with every passing day.

However, the chairman and I agree that health care providers and payers of all shapes and sizes need to work together to provide patients with higher quality, better coordinated care. According to the Medicare Payment Advisory Commission's most recent report in 2010, individuals, government and businesses spent a total of \$2.6 trillion on health care. Today, about 45 percent of all health care spending comes from government.

In 2014, when the Medicaid expansions begin, that share will rise to 50 percent. The Congressional Budget Office projects that by 2021, just 8 years from now, spending on Medicare and Medicaid will grow to \$1.6 trillion.

By virtue of its sheer size, Medicare has an important influence on the overall health care delivery in our country. Clearly, with the right policies in place, Medicare can be a driver of change. Now, that being said, I also question whether the program can be as nimble as the private sector in making systemic improvements.

Mr. Blum, I hope that you will be able to reassure us that it can be. As most health care providers will tell you, in addition to the rapid aging of our population, we have to contend with an increasing number of patients with chronic diseases, such as diabetes or heart disease. These patients are sicker and more expensive to treat. While providers are doing their best to manage these patients, oftentimes our health care system is not structured to allow care to be easily coordinated.

Currently, we have a system of isolated silos. Patients receive care in a variety of settings: doctors' offices, hospitals, nursing homes, et cetera. It is not uncommon for a health care provider to have an incomplete picture of a patient's overall care.

In addition, provider incentives created by potential malpractice liability, and patient incentives created by insurance choice mechanisms, are not well-aligned to put the proper focus on better results and lower costs.

We can certainly continue to tinker around the edges of delivering care in new ways, but providers continue to tell me that fear of lawsuits drives the volume of services. Of course, our fee-for-service system provides little financial incentive to manage care properly. As a former medical defense lawyer, I have to say it was bad back then more than 37 years ago, and it is even worse today.

When talking about delivery system reform, our goal should be to ensure that patients receive the right care in the right place at the right time. There is an appropriate role for both the private payers and the Federal Government to put pressure on providers to reduce costs and provide better care and better health outcomes.

Now, I know that Rome was not built in a day and big changes will take time, but I think we have to move beyond simply reporting what providers are doing to holding them more accountable for health care outcomes.

In my own home State of Utah, we are privileged to have some of the best, most efficient health care providers in the country. But not all providers are created equal. Much of our health care system is fragmented, and often the right hand does not know what the left hand is doing. Unfortunately, the patient is caught in the middle with very little coordinated care.

Now, I am anxious to hear from you, Mr. Blum, about any real progress CMS has made in moving towards greater care coordination. We know that many errors and costs can be avoided when providers focus on care transitions. Lately there has been a lot of attention paid to the flourish of activity coming from the Center for Medicare and Medicaid Innovation, also known as CMMI.

Like many of my colleagues, I remain concerned that CMMI has an enormous budget and very little accountability. I am hopeful that we will hold another hearing this spring that focuses exclusively on CMMI and the results of the \$10 billion in taxpayer money that was given to them to advance the cause of higher quality, lower costs, and more efficient care.

And so, Senator Baucus, thank you for convening this hearing today. I look forward to hearing from Mr. Blum. I am hopeful that he will have some good news to share with us on the progress CMS is making to help bend down the cost curve.

The CHAIRMAN. Thank you, Senator.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. I might tell some of my colleagues and friends here that Mr. Blum is no stranger to the Finance Committee. He was on my staff for a while, and he was also the principal advisor down at the witness table on MMA not too long ago. It is hard to resist the temptation to explain what a bright person Mr. Blum is. I do not think I have met anybody brighter and smarter, certainly in health care, ever. This guy is good. So I am glad you are here, Jon.

As an introduction, Jonathan Blum is the Acting Principal Deputy Administrator at the Centers for Medicare and Medicaid Services and Director for the Center for Medicare. It is great to have you back here, Jon. It is good to see you. You know the rules here. Your statement will be in the record, and speak for about 5 or 6 minutes.

STATEMENT OF JONATHAN BLUM, ACTING PRINCIPAL DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR MEDICARE, CENTERS FOR MEDICARE AND MEDICAID SERVICES, BALTIMORE, MD

Mr. BLUM. Chairman Baucus, Ranking Member Hatch, committee members, thank you for the opportunity to discuss our progress to strengthen the Medicare program and transform the delivery of care. In the 3 years since passage of the Affordable Care Act, I am pleased to report on our progress.

We have put in place many new programs and policies following the goals of the health reform law. For the first time, we can say we are paying for value, not simply the volume of care. Quality is improving, and costs are growing more slowly. Simply put, Medicare's cost curve has been bent downward.

Over the last 3 years, CMS has put in place new payment mechanisms to reward hospitals for the overall quality of care. CMS has finalized regulations to define what it means to provide accountable care, the so-called ACO regulations. We have transformed our physician payment system to shift its emphasis towards primary care services and care coordination.

We have established a new Center for Innovation, which is currently testing more than 35 new programs and is working with over 50,000 health care providers and over 3,700 hospitals. We have shifted the business model for private plans competing in Medicare. Before the Affordable Care Act, plans competed on low premiums and extra benefits. Today, they compete on low premiums, extra benefits, and the quality of care they provide their members.

CMS has transformed our framework to respond to fraud and abuse, to stop fraud before it happens rather than chasing down providers for payments after they occur. CMS has overhauled the payment model for durable medical supplies and home health care,

dramatically lowering spending without compromising quality of care.

Over the next several months, CMS will focus on several new areas. We are working with hundreds of hospitals and health care providers to test how to bundle fee-for-service payment together in new ways to figure out the best way to pay for a total episode of care.

We will continue to work to implement the value modifier policy to continue to shift our physician payment system to reward top-performing physicians and providers. We will continue to partner with States to test ways to best provide and coordinate care, including to vulnerable populations such as the dual-eligibles.

Given our work to date, we can now provide this committee data that begins to demonstrate that the strategies put in place over the past several years are working. There are four data points that I believe should give us great optimism. As Senator Baucus said, we have more than 250 ACOs operating within the traditional fee-for-service Medicare program, serving more than 4 million Medicare beneficiaries. This tells us that providers and physicians are stepping forward to participate in new payment and delivery models.

Data point number two: after more than 5 years of holding steady, the rates for all-cause hospital readmissions are starting to trend downward.

Point number three: 37 percent of Medicare beneficiaries who have chosen a private Medicare plan are in a 4-star/5-star plan, 5-star being the highest quality. This is up from 16 percent 4 years ago. Quality of care is improving.

Data point number four is the most exciting: the rate of growth in per capita Medicare spending—per capita Medicare spending—has been at historic low rates for 3 years in a row. This is tremendously exciting from our perspective.

To be sure, we have more work to do, but the work to date and the data that we are seeing should give us great hope that we can bring Medicare to a sustainable financial footing and to improve the quality of care.

I will be happy to answer your questions.

The CHAIRMAN. Thank you, Mr. Blum.

[The prepared statement of Mr. Blum appears in the appendix.]

The CHAIRMAN. My first question is about the degree to which you are coordinating all this with the private sector. It is one thing for Medicare and CMS to put together an Accountable Care Organization, but clearly, if this is going to work, you have to be talking with, working with, coordinating with, the private sector too to get some of the same agreed-upon incentives for results.

If you could just describe a little bit how successful that has been, the degree to which you are working with the private sector, with companies and insurance companies, et cetera, and the progress you are making.

Mr. BLUM. Sure. There are a couple of ways to answer your question, Senator. The first is that we study very carefully best practices and talk to private payers, talk to State Medicaid programs, to really understand what they are trying to implement so we can repeat or build off of best practices. There are some very exciting programs within private payers to foster medical homes, for exam-

ple. So we try very hard to understand how the private sector is creating new financial incentives.

We also try to craft our regulations in a way that is open and transparent so private payers can copy—not copy, but to try to build off of—the CMS Medicare experience. For example, we hear from large private health plans that they are also working to establish ACOs for their contracted physicians, built off the ACO regulations that CMS has finalized.

Finally, several of our new innovation models that are being tested really have an all-payer component to them—the Pioneer model, for example. In order to get the Pioneer contract for the ACO pilot, the Pioneers had to demonstrate that they also had risk-based contracts with private payers to demonstrate that they were not just working with the Medicare program, but working within the entire health care system.

We have another pilot that is through the Innovation Center to test how to build primary care medical homes. That too has an all-payer concept where the providers who get the contract from CMS have to demonstrate that they are also working with private payers to ensure that we are all aligning and pointing in the same direction.

We hear from others that they are building off the value-based purchasing strategies, so we are always trying to learn from best practices, trying to incent all payers to point in the same direction, but also to craft regulations that can serve as models for private payers.

The CHAIRMAN. You have a lot of demonstrations going and set up. When are we going to see results? You have demonstrations, I think, aligned with CMMI. Senator Hatch referred to it. You mentioned the 250 ACOs. There are a lot of other demonstrations going on. When are we going to see some results?

Mr. BLUM. Well, I think one result that we are seeing, which I believe is due to a combination of different factors, is the reduction in all-cause hospital readmissions. When you think about being 1 percentage point lower than the previous 5 years, that translates roughly to 20,000 fewer readmissions per month. I believe that it is due to the payment policies, the new innovation models that are being created. So there are some results.

The challenge now is how to assign cause and effect. Many of these models were started in the last 1 to 2 years. We expect that to fully see results, it will take 2 to 3 years. There are up-front costs for providers to build a model to create their data systems.

I think we need to be cautious in looking at 1st-year results, but we are very much committed to sharing the data that we see. My boss, Secretary Sebelius, is very anxious to see results as well. Any model that is scalable, that can be scaled, has to go through the rigorous review of the Chief Actuary, but we are very much committed to share our learnings.

But I think one positive learning is that providers are very eager to step up. We are overwhelmed by interest. I think there is some skepticism—

The CHAIRMAN. Do you have a system of interim results?

Mr. BLUM. We set up very carefully, and we build every model with the assumption that it can be scaled. The law requires that

any model for the Innovation Center, in order to be scaled, has to pass that rigorous review by the Chief Actuary.

So our team develops the data capabilities, the monitoring systems, really with the end point hopefully being that these models can be brought to scale, but they have to first pass that rigorous review.

The CHAIRMAN. Yes. But does it make sense for you to share with us, at the appropriate time, the interim results too? Because we want to keep informed and, frankly, just keep your feet to the fire.

Mr. BLUM. Absolutely. We are happy to work with you and your staff to figure out a way to best share results, to share data. That is our commitment to this committee.

The CHAIRMAN. All right. Well, I would like to work out some system where that happens—

Mr. BLUM. Absolutely.

The CHAIRMAN [continuing]. Where the results and the data are shared. Thank you.

Senator Hatch?

Senator HATCH. Thank you, Mr. Chairman.

We are grateful for the work that you do, Mr. Blum. As described in your testimony, each payment reform initiative has different incentives or penalties attached to it. Are those proving to be strong enough to actually change provider behavior?

Mr. BLUM. I think so. Clearly we have to continue to study the trends that we are seeing, but the trends that we are seeing are moving in the right direction. I think one of the exciting trends that we are seeing is hospitals that traditionally operated within silos are now establishing ties to the community, to post-acute care providers, to physician networks.

I think one of the most exciting transformations that we are seeing is what you described: the goal of better integrating the silos of care that we have within the traditional fee-for-service program. So we need to continue to evaluate whether or not we have strong incentives, but I believe the trends we are seeing are due to the combination of payment policies, but also the continuous push by the Congress and by CMS to better integrate care.

Senator HATCH. Are there delivery system reform initiatives under way in which CMS has not waived Stark or anti-kickback rules? If so, what are those initiatives, and why are the rules not waived?

Mr. BLUM. I would have to double-check for you, Senator, which demonstrations have waived Stark and anti-kickback and which have not. With the ACO program, we really worked hard with the oversight agencies, the Federal Trade Commission, Department of Justice, to review ways to relax those requirements, but at the same time still uphold the oversight principles that we have.

We have come into the framework temporarily that is going to continue to go through review that, if providers can demonstrate clinical integration, that working together in new ways really improves the clinical model, then we are comfortable relaxing some of those requirements. We have in the ACO regulations a time-limited period.

We will continue to monitor whether we are seeing any behaviors that are troubling, but I think the goal really is, not just to look at the payment but the entire oversight framework, to ensure that we can best integrate care for true clinical improvement. But I would have to get back to you, to your question.

Senator HATCH. All right. We would appreciate it, if you would.

The Patient Protection and Affordable Care Act cut \$306 billion out of the Medicare Advantage program to create a new entitlement. Now, this is especially concerning, since currently more than one in four seniors, including a significant number of low-income and minority beneficiaries, have come to rely on the better benefits, enhanced care coordination, and higher quality coverage offered through the Medicare Advantage program.

According to external estimates, the combined effect of the sequester, PPACA's cuts, and higher taxes and other harmful new policies, will result in at least an 8-percent cut to the Medicare Advantage program for calendar year 2014.

Now, I understand that some of the rates and policies announced on February 15th in the advanced notice are governed by the statute, but CMS does have considerable discretion over many of the policies that have been announced.

Towards that end, I want to clarify where you have discretionary authority regarding the rate notice. As we both know, CMS has historically chosen to develop MA rates based on the assumption that Congress will not patch the scheduled physician payment cuts, and therefore payment rates to MA plans are artificially low.

Do you believe that the statute prevents CMS from assuming more realistic payment rates, especially given the fact that Congress has fixed the SGR for the last 11 years? If you could answer that in a simple "yes" or "no," I would appreciate it.

Mr. BLUM. There are many elements to your question, and I will try my best to answer all elements to your question.

Senator HATCH. All right.

Mr. BLUM. We have been tremendously pleased to see the dramatic growth in Medicare beneficiaries choosing private plans since passage of the Affordable Care Act. Beneficiaries who are in private plans are at an all-time high, nearly one-third. At the same time, premiums have come down dramatically, 10 percent in 2012.

Our goal is to do two things at the same time: to ensure that beneficiaries continue to have strong choices to plans, but at the same time make sure that our payments are accurate. Our rate notice that is proposed has proposed some changes to our payment methodology.

One of the reasons why the rates are proposed to be lower is the fact that overall Medicare spending is lower, so it is a very good new story for the overall Medicare program. We have also taken our discretion to propose changes to the risk adjustment model that we use for plans, and that is an area where CMS does have discretion.

It is CMS's long-term practice not to assume the costs for the SGR fix that always happens after the rates are finalized to our rate notice. We have received comments for us to take a second look. But I think the best way for us to stabilize the MA program is for a long-term fix to the SGR.

Senator HATCH. My time is up, but I have another question on this on the arbitrary price controls known as total beneficiary cost thresholds. I will submit that in writing, but I hope you will answer that for us as well.

Mr. BLUM. Sure. Of course. Thank you, Senator.

Senator HATCH. Thank you.

The CHAIRMAN. Thank you, Senator. Thank you, Mr. Blum. The last question the Senator asked is an important one. We are going to have to find a solution here.

Mr. BLUM. All right. I understand.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. Welcome, Mr. Blum. I have long known of your good work.

Let me ask you about your response to the fact that Medicare reimbursement varies dramatically across the country. A number of us—I see my colleagues Senator Cantwell, Senator Grassley, a number of us—on a bipartisan basis have focused on the fact that our States really get clobbered by the Federal Government for doing a good job. We essentially get penalized for giving good quality and holding costs down.

Now we are starting a very good model, one we like: the question of a shared savings approach to incentivize quality. Our concern is, what are you going to be able to do to address the fact that low-cost States like ours are going to be disadvantaged at the get-go because we start off with this lower reimbursement rate?

Mr. BLUM. I agree with you, Senator, that fee-for-service payments and quality vary dramatically across the country. We have some parts of the country that operate at very high quality levels at low cost. I think our overall goal, and I believe this is the goal of the Affordable Care Act, is to develop policies that promote more parts of the country—hopefully all parts of the country—to operate the highest quality level at the lowest cost, total cost of care.

But you also see tremendous variation, not just between regions of the country but within regions, so you can have the lowest cost part of the country and have dramatically—

Senator WYDEN. Your approach then to make sure we do not get penalized is to say that somehow we will just use our region as a measuring rod because—

Mr. BLUM. No.

Senator WYDEN. Go ahead.

Mr. BLUM. Sorry. I am sorry to cut you off.

Senator WYDEN. Yes. We just want to know how we are not disadvantaged at the outset.

Mr. BLUM. I believe that the best payment strategy for the traditional fee-for-service program is for us to create incentives at the hospital level, at the physician practice level, to reward high-quality care and lowest-cost care. That is why I believe that our value-based purchasing program for hospitals is so important, because over time it will reward hospitals not just for better quality of care, but lower total cost of care.

The value modifier physician proposal that we are working to implement is also vitally important to the strategy, but I think the overall goal should be to create the incentive structure, not at the regional level, but at the provider level, the physician practice

level, because even in low-cost regions there is still tremendous variation within that region.

Senator WYDEN. I certainly support the goal and where you are trying to go. I am just not sure we are going to get there very fast unless we root out what is a baked-in discrimination against a lot of parts of the country that have given good quality and have been penalized for it. So, we will be following up with you on that.

I want to ask you one other question about chronic care, which, as you know, is where most of the Medicare dollar goes. It is 70 percent of the Medicare dollar: heart, stroke, cancer, diabetes. It just continues to escalate, if you look where Medicare was in 1965 when it began and today. Senator Hatch noted it in terms of that article in *Time* magazine. That is where the Medicare dollar goes.

So I looked at the two models in Medicaid and Medicare, with respect to chronic care. It looks like you all are working on a very effective model with respect to Medicaid and the role of the States. The health home specifically targets coordinated care for those who have these chronic conditions. It does not seem to me that Medicare is doing that.

In fact, the Medicare program has a different name, as you know, but it looks like it is mostly about realigning payments for doctors and primary care. It does not put the same focus, particularly given the growth of Medicare, as it relates to chronic care.

I want to shore that up. What else can be done, in your view, consistent with the statute or other ideas, to give us a chance to target in on where most of the Medicare money goes? We deal with that 70 percent, and you are a long way from dealing with the demographic tsunami and our big challenges.

Mr. BLUM. Those are great questions, Senator. The first wave to our work with the Innovation Center was really around building the accountable care model and strong primary care medical homes within Medicare. That was phase 1 to our work with the Center for Innovation.

But we are hearing from physician specialty societies, for example oncologists, that want to shift to a different model, that want to be accountable for the total quality, total cost of care. The same is true for cardiology.

So I believe that phase 2 of our work within the Innovation Center will be to really build upon the shared savings models that we have within the ACO context, but then to start to channel the energy that we are hearing from physician specialty societies to build payment models specific to chronic conditions—oncology, cardiology issues—and that I think is the promise for the next wave for the Innovation Center.

Senator WYDEN. I know my time is up.

Senator HATCH. Senator Grassley?

Senator GRASSLEY. Yes.

Senator HATCH. Thank you, Senator.

Senator GRASSLEY. Say, you know, Mr. Blum, it is always good to see a former Finance staffer triumphantly come to one of those chairs you are in.

Mr. BLUM. It was always easier to sit behind you than to sit in front of you. [Laughter.]

Senator GRASSLEY. Well, good. I think, like a lot of my colleagues, I have grown to have serious concerns about Medicare's fee-for-service payment system. Referring to your testimony, you outline all the ways that Medicare is trying to improve care coordination. I appreciate the steps that you are making, and you are going to continue forward on that.

I want to focus on the system that you are stepping away from. So is there any defense—with emphasis upon any—for Medicare or fee-for-service where a provider is paid based on the quantity of service provided without any regard for the outcome or quality of care provided, or any responsibility to coordinate care with other providers?

Mr. BLUM. I believe that we should work—and Congress has given us this charge—so that every fee-for-service payment system that CMS maintains is tied to quality: quality of care outcomes and the total cost of care.

We are further along within the hospital payment system, and that payment system is increasingly tied to the outcomes and the total cost of care, not just the care that is provided within those four walls of the hospital. Over time, CMS is authorized and charged to transform all these payment systems to achieve the same goals. We have to make sure that we have the right measures; we have to make sure that we do not create perverse incentives.

But I agree with you, Senator, that we need to work together, and CMS is committed to do this with this committee to make sure that all of our payment systems begin to adopt the same principles that Congress has authorized for the hospital payment system.

Senator GRASSLEY. Yes. So there is not any defense of Medicare fee-for-service anymore. We are working away from it, so there is no defense for it. Thank you very much.

In reference to the chart here, since you mentioned coordination between Medicare and Medicaid, I would like to bring up something with you that I discussed with Melanie Bella when she came to testify recently. The chart shows the most expensive Medicare beneficiaries.

These are the people with multiple chronic conditions and functional impairments: 57 percent are eligible for Medicare only; 43 percent are dually eligible. The current duals demonstration appears to be focused on giving States greater control over acute care for these most expensive beneficiaries.

[The chart appears in the appendix on p. 47.]

Senator GRASSLEY. Some rhetorical questions, then I am going to ask you for your comment. Why are we splitting up these two groups? These are two groups of similarly situated individuals. They all have need for improved, better coordinated care. They have multiple conditions that are expensive. Why do we tell some people, you have income, so you get Medicare; you do not have enough income, so you get solely Medicaid?

Why is it a good idea to give States control over low-income beneficiaries? Why should low-income beneficiaries get one of any 50 different models to coordinate their care, and people with income get Medicare? So, I would like to know what you think, because I

am very concerned about splitting these individuals. The splitting of these individuals makes no sense.

Mr. BLUM. Well, as the person who oversees the Medicare program within CMS, I believe that the models that we are testing to better integrate dual-eligibles do not take away any rights or benefits that dual-eligible beneficiaries are entitled to in the Medicare program. In fact, the models that Melanie Bella is leading to set up will strengthen Medicare, will have more oversight, will have more control. I think most dual-eligible beneficiaries are in the fee-for-service Medicare program that you described. The care is uncoordinated.

Beneficiaries balance between different care settings, and we want to make sure that we are using the best of the Medicare program, the best of the Medicaid program. So, in my view, I do not believe that the dual-eligible demonstrations are ceding that control to States, but rather they are building a very powerful Federal/State partnership to take the best of the programs, to have even better benefits, more coordinated care for these beneficiaries.

But I think, really, the goal should be to make sure that these beneficiaries have better care, more coordinated care, and to reduce the duplication that you described during your first question.

Senator GRASSLEY. Thank you, Mr. Blum.

Thank you, Mr. Chairman.

Senator HATCH. Well, thank you.

Senator STABENOW?

Senator STABENOW. Thank you very much. Welcome, Mr. Blum. It is good to have you before the committee.

I just want to start by reiterating what I think is important news of what you have been saying today. We all know that we have many challenges around health care costs. That has been our focus as we have looked at how we put in place health care reform that works for people with quality, but also brings down costs, and how we actually reduce costs and not just shift them around, which is what the health care system has done when somebody cannot see a doctor and they go to the emergency room. It costs a lot more money. How do we make sure we are actually not just shifting costs around?

But, if I understood you right, you were saying right now we have 250 Accountable Care Organizations so far. The rate of hospital readmissions is going down, quality is going up, rate of cost growth per capita is going down. The Medicare Advantage program has seen a 10-percent premium reduction as well as, I have seen, a 28-percent increase in enrollment, something like that. So we know that part of that is bringing down the overpayments in Medicare Advantage, which is significant savings under Medicare.

I wonder if you could speak a little bit more to Accountable Care Organizations. We have a number of things happening in Michigan that are actually very exciting in terms of the possibilities.

The Detroit Medical Center has been working with a group called At Home Support to help the sickest patients get advanced support at home and prevent hospital readmissions so that if you have, as an example, an 87-year-old patient with stage 4 heart disease who wakes up in the middle of the night and they would normally, if they have concerns, go to the hospital emergency room, be in the

hospital, come out, go to a skilled nursing facility, and so on, all of which costs tens of thousands of dollars and certainly is not the way they would like to spend their time, under this, the same woman would get at-home services, be able to call the nurse in the middle of the night, be able to get help and possibly be able to stay at home rather than go through everything at the hospital.

Could you talk a little bit more about the ACOs and how you see them expanding in the importance of really making sure those kinds of things are successful?

Mr. BLUM. Sure. But we have been very surprised and pleased with the response that CMS received to the ACO program. The program has 250 ACOs, and we expect that number to continue to grow. The program was authorized by Congress to have an annual process to allow more organizations. What is really exciting about the ACO program is they are being started by physician practices in large part, so it is not necessarily just hospitals that are developing ACOs, but physicians are beginning to step forward.

We created different tracks. The Pioneer model, for the most advanced organizations, is really to show us what is possible, to build more advanced accountable care models, but also to teach others who are coming into the game for the first time.

But to your point, Senator, the ACO model really is about making sure that care is paid for in non-face-to-face settings, that physicians have greater resources to coordinate care, to manage care, to build the infrastructure of nurse practitioners, nurses, other health care professionals, to watch patients navigate through the health care system.

But I think the ACO model really is one of our most promising models to transform fee-for-service, to give the incentives for the care coordination, and to reward providers for the non-face-to-face time that happens to best manage patients through the health care delivery system.

Senator STABENOW. We have more to do, but it is certainly optimistic right now as we get started in this. I wonder if you might also speak to another type of demonstration project, the Strong Start initiative, which is focused on pre-term births, basically premature births, that put both moms and babies at risk. This is included in maternity care home demonstrations. In fact, a number of us are working on legislation we are re-introducing today called the Quality Care for Moms and Babies Act to increase quality standards as well.

But we have three of those projects in Michigan. One is run by Meridian Health Plan and Legions Hospital, and it is focused on being able to reduce premature births, which are costing the country about \$26 billion a year, not to mention what is happening to children. I wonder if you might talk a little bit more about the progress in those kinds of areas and what we are learning from preliminary results there.

Mr. BLUM. Sure. Well, I think, Senator, the goals of the project really are to reduce the number of pre-term births. That is potentially harmful, both for mothers and for children.

We have just begun this demonstration. We are watching the results very carefully. We will be sure to bring information. But really the premise behind the demonstration is to take evidence-based

protocols and to disseminate those to care providers to create the message that pre-term birth is potentially harmful in many cases. But we will pledge to share results as soon as we receive them, but we are very excited about this project.

The CHAIRMAN. Senator Thune?

Senator STABENOW. Thank you.

The CHAIRMAN. Thank you.

Senator THUNE. Thank you, Mr. Chairman.

I wanted to get in one question quickly about delivery of health care in rural areas, and that has to do with the 2009 CMS ruling, or policy, I guess I should say, regarding direct physician supervision of outpatient therapeutic services.

Hospitals, physicians, and rural health care organizations recognize this change as a burdensome and unnecessary policy change, but CMS characterized the change as a “restatement and clarification” of existing policy in play since 2001.

In its attempt at clarification, CMS retroactively interpreted the policy to require that a physician privileged by the hospital provide supervision and be physically present in the same outpatient department at all times when outpatient therapeutic services are furnished, when historically that has not been the practice.

I am concerned that CMS’s “clarification” is instead a significant change in Medicare policy that would place considerable burden on hospitals, especially on facilities in rural areas. I am also concerned that the panel convened to advise on this issue is not sufficiently considering the input from rural critical access hospitals. My question is, will you agree to return to the pre-2009 interpretation of this policy?

Mr. BLUM. Well, in 2009, you are correct, CMS made some, what we call policy clarifications, but I believe the critical access hospital community may have interpreted them as fundamental changes. We heard a lot of concerns; we heard a lot of complaints.

In 2010, I traveled through North Dakota—not South Dakota, but North Dakota—to meet firsthand with critical access providers, and we heard tremendous concern regarding the challenges that our clarification would provide critical access hospitals. We decided to back down, to slow down, to create this physician-hospital provider review panel to help us understand which services do not require direct physician supervision. That is the framework that we are moving.

My understanding is that it is working better from the critical hospital’s perspective, but we would love to hear your views of how we can improve that. But I believe that we are working to address the concerns that we heard during 2009, and seeing the hospital care first-hand was very helpful for me to understand how to work together with the hospital community to solve this issue.

Senator THUNE. I am glad you went out and got some of that perspective, and we would be happy to provide the feedback that we get from providers in our part of the country, because it is a really important issue in terms of delivery of health care.

Mr. BLUM. Absolutely.

Senator THUNE. Your testimony outlines a long list of initiatives that CMS is implementing with the goal of improving health outcomes and lowering costs. The question is, if these proposals are

going to sufficiently lower health care costs for taxpayers and patients, why is the Independent Payment Advisory Board necessary?

Mr. BLUM. Well, the independent board is outside of CMS, is my understanding, so I cannot speak to it directly. What I can say is, from the person operating the Medicare program, it is tremendously helpful to have pressure from Congress, from outside boards, to keep spending low.

We work in CMS to ensure that we are building policies to keep spending low, to ensure quality is improving at the same time. But having that system of checks is tremendously helpful to ensure that we are pushing out all of our payment systems in a way to maximize quality but to reduce total cost of care.

Senator THUNE. But it does not sound like it is all that necessary for you to accomplish the initiatives and the things that you are trying to accomplish here. Those are things that CMS is doing on its own.

Mr. BLUM. What I would say, Senator, is this focus needs to continue. The pressure needs to stay on. There are multiple ways to receive that pressure, but having that pressure is the best way, in my judgment, to continue the focus that has been there for the past several years.

Senator THUNE. The last question has to do with electronic health records and the rate at which CMS is implementing the stage 1. In the last 6 months, I think stage 1 has been implemented. They published a final rule for stage 2 and are already seeking feedback on stage 3. There are still a lot of reports out there that question the effectiveness of EHR adoption.

My question is, do you believe that CMS is conducting appropriate data review before accelerating into stage 2 and stage 3 to ensure that that program is on an appropriate path towards interoperability between unaffiliated health systems or providers?

Mr. BLUM. I think there are a couple of ways to answer your question, Senator. We are pleased with the rates of adoption of hospitals and physician practices to respond to these new incentives. One of the things that we hear from entities that are participating within our new delivery models like ACOs is that the model would not be possible but for a strong electronic medical record.

So I believe that we have to evaluate the impact to the EHR program, not just the program itself, but the total changes that we were seeing within the health care delivery system. So, hospital readmissions coming down, that is a sign to me that health care silos now are talking to each other better to reduce the lack of care coordination.

We are committed to overseeing the program. We are happy to work with you and your staff to understand how we can best oversee. We are also concerned about some of the reports that EHRs may lead to inappropriate spending or services. We take that concern very seriously. But we are committed to ensuring this program continues to expand, while also preserving the integrity of the programs.

The CHAIRMAN. Thank you.

Senator THUNE. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman. Again, thank you for having this hearing and many of the hearings that you are having on this subject of the implementation of the Affordable Care Act. I think it is of the utmost importance, given the size and scale of its impact to our economy, that the agency is held accountable during this process.

I certainly appreciate the reminder that Mr. Blum used to be a member of the staff here, so maybe he could become an extraordinary emissary to the agency as it relates to its communications, because I can think of many things that many members here have shown a level of frustration about on the implementation of the Affordable Care Act.

I wanted to follow on with my colleagues, Senators Wyden and Grassley, about the value index for physician payment. You talked about what has happened with hospitals. The physician payment, I think Mr. Elmendorf said it was probably one of the most cost-saving provisions of the bill. I want to get an update on the progress.

I actually have three questions for you, so hopefully I can get through all that in 5 minutes. But talk about the progress of that value index as it relates to physicians and why we do not just put out a global rate: if you fall below that, you are rewarded, and, if you fall above that, you are penalized. And some progress on the rebalancing from nursing home care to community-based care—do you see that as a big cost saver?

So, if you could start with those two.

Mr. BLUM. Sure. Thank you for the questions. I believe that the value modified physician payment change that was authorized in the Affordable Care Act has the potential to be one of the most significant changes to the fee-for-service Medicare program. It is also one of the hardest—probably the hardest—policy that we are working to implement, from a couple of different perspectives.

The challenge is, Medicare beneficiaries who have many chronic conditions see many physicians. They can see 12, 15 different physicians in the course of a year. How you can assign the accountability for the patient's total care is very challenging when they are seeing multiple primary care physicians, multiple specialists. So we have chosen to phase in the value modifier by first starting with large physician groups that have over 100 professionals, because we have the greatest confidence that we can assign value and quality to that large practice.

We are very much committed to the policy. We are committed to the schedule that was outlined by the Congress, but this is the hardest policy, and we are going to need all the advice we can get from this committee and the physician community. But we have started the process that will take effect in 2015, and you will see more rulemaking for policy this year to continue the phase-in.

Senator CANTWELL. I think it starts in 2013 and is not fully implemented until 2017, or something of that nature. So I think we have lots of time, so it is good to hear that you think it is one of the biggest cost savings.

I wanted to ask you about the basic health plan. One of the issues here is saving dollars within the Medicare budget, because Medicare is going to take everything that we have, just because of

the aging population and living longer, so we want to get it right. But in the Affordable Care Act we have two provisions of the basic health plan, which are annual costs and premiums a lot lower than what we would face on the exchange, and then the population, if we could see that chart for a second. Put it over here.

[The chart appears in the appendix on p. 48.]

Senator CANTWELL. This particular population is a very narrow population on the exchange, but somehow the agency seems to be very anxious, instead of implementing the law in 2014 as called for by the Affordable Care Act, it seems to be anxious that somehow giving this population just above the Medicaid rate a more affordable benefit plan as outlined in the first chart is somehow against the interests of the overall Act. If you could shed any light on that, I would certainly appreciate it.

Mr. BLUM. I have a couple of ways to respond, Senator. I have not personally worked on this issue, so I cannot speak to the decision-making behind it. I do understand that Marilyn Tavenner has promised to provide you a schedule of how we plan to implement this provision, but we are happy to work with you and to help best answer those questions.

Senator CANTWELL. Well, Ms. Tavenner definitely will not have my support. I am not interested in how she is going to implement the Act. I am interested in the commitment of the administration to live up to the way the Affordable Care Act says the provisions should be implemented.

Right now I cannot get anybody at CMS to own up to the fact that States, under the law, could receive 95 percent of the tax credits to provide cheaper care, as the first chart showed, to the beneficiaries instead of making them out-of-pocket expenses.

So I am not interested in having the schedule of what date it is going to get implemented, I am interested in the agency making sure that it does not thwart a more cost-effective solution to somehow save the exchange when that is really a false issue, in my viewpoint. So, thank you so much.

Mr. BLUM. I understand.

The CHAIRMAN. Thank you, Senator.

Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman.

Mr. Blum, thank you for being here, and thank you for what you do. It is impressive that you have a 3-year record of bringing per capita costs down. Delivery system reform is clearly the best hope we have of continuing that trend, so this hearing is particularly important.

I want to talk about a recent decision that was made in regard to the Affordable Care Act's pediatric dental benefits, which has me concerned. We are at the 6-year anniversary of the death of Deamonte Driver, a 12-year-old who died in my State because timely dental care was not available. We have made a lot of progress in the last 6 years through the Children's Health Insurance Program Reauthorization Act and the ACA, and I really applaud the efforts that have been made.

It is my understanding that you are now allowing for a separate out-of-pocket limit for coverage through stand-alone dental plans. I am concerned that you are implementing discriminatory policies

similar to those that were put in place decades ago for mental health services—policies that say this is 2nd-class health care rather than part of the essential benefit package, which was our intent in the Affordable Care Act.

Can you share with me what leadership has done at CMS to make sure that there is reasonable coordination of benefits so that our intent of providing pediatric dental care will in fact be a reality, particularly where the Federal Government is establishing exchanges?

Mr. BLUM. Well, I think one of the lessons that we learned within the Medicare program is that, when the care is siloed or our benefits are not fully integrated, that can often lead to worse total health care consequences.

I can pledge to get back to you with direct answers to your questions, but I do agree with your general principle that, when benefit design is broken up and care is not coordinated, it can often lead to bad quality of care. So, I will be happy to get back to provide direct answers to you.

Senator CARDIN. I appreciate that. The Federal Government will be playing a key role in many States by setting up the insurance exchanges, so I think there is a real opportunity for you, as the exchanges are set up, to show leadership, and I look forward to you getting back to me.

Let me ask you a question about minority health. The Affordable Care Act put a high priority on health equity by establishing several HHS Offices for Minority Health to deal with racial and ethnic disparities. We have made some progress in closing the gaps. In looking at cancer death rates released yesterday by the American Cancer Society, generally there has been progress made, but with regard to colon cancer and breast cancer, two diseases for which screening and treatment are critical to proper care, the disparities are growing.

What is CMS's commitment to dealing with minority health issues to reduce such disparities?

Mr. BLUM. The commitment is tremendous. I believe the Affordable Care Act, which is now established, requires CMS to set up a separate office to focus on minority health to make sure our programs are coordinated and responding to the challenges.

One of the things that we have done, particularly with the flu vaccine, is, now that we have the capability within CMS to track claims, pinpoint zip codes, pinpoint geographic areas so we can target resources, I think the best strategies we can employ to ensure that screenings are taken advantage of is to use this technology to build community programs.

We are working much closer with public health organizations, really to help all beneficiaries, and particularly to focus on the pockets of the country where we see screening use lower than the national average. But we are happy to continue to hear ideas, but I agree with your statement.

Senator CARDIN. If you would keep my office informed as to the resources being devoted to these efforts and the progress that is being made, we would very much appreciate it. There are seven offices in key Health and Human Services agencies that are positioned to help close the gaps in quality and access, and we believe

it is essential to coordinate, track, and measure the efforts that are being made. So, if you would keep us informed, I would deeply appreciate that.

One last question on the Medicare outpatient rehabilitation therapy caps. As the author of legislation since 1998 to repeal this misguided policy, I believe we all hope to get a permanent policy on the therapy caps so we do not have to deal with it every year. In the wisdom of Congress, we imposed a new requirement in 2011 for manual medical review of higher-cost cases. I am not so sure how wise that was, and I am concerned that we are creating yet another bureaucratic hurdle for patients and providers. I am told that there is inconsistency in how the various Part B fiscal intermediaries are handling the new process, leading to confusion across the Nation. Beneficiaries and the therapists who treat them need predictability, and they deserve a sound policy that reimburses based on the patients' need, rather than on arbitrary limits.

Can you share with us, either now or later, how you plan to implement the new policy in a way that will not lead to additional problems for providers?

Mr. BLUM. Sure. I think whenever we have policies that suspend in 12 months and have to be reauthorized, that creates challenges for providers and creates challenges for beneficiaries. I think the principle should be that beneficiaries should know what their benefit levels are and that providers should see predictable payment.

I think one of the ways to address the therapy cap long-term is to ensure that we pay appropriately for therapy services. This is an area where we see abuse, particularly in certain parts of the country. We have tried to improve the payment policies by paying for services provided together at the same time.

So I think a combination of smarter payment policies targeting the bad actors—not all therapists provide fraudulent care—but I think a combination of better payment policy, and disciplined fraud and abuse approaches, will hopefully relax the need for Congress to continue to have to reauthorize this policy.

Senator CARDIN. Thank you.

Senator CARPER. Thank you.

Senator Casey?

Senator CASEY. Thank you so much. We are grateful for your testimony and your presence here, and obviously your public service and the ways that our office has engaged with yours. I am grateful for that. This is very difficult to tackle, these issues that relate to delivering better care at a lower cost. But it seems like you are beginning to unlock that door, so to speak.

I want to ask you, based on what you know already—and I know in some ways it is still in the early stages, but you are already seeing some good results—is there anything that you have learned, or at least begun to ascertain, about the delivery system results in Medicare that you might be able to apply to Medicaid?

Mr. BLUM. Well, I think one of the lessons that I have taken is that, when providers see complete data on their beneficiaries, it opens up many new opportunities for better care coordination. I think one of the major benefits that the ACO participants have now is the ability not just to see their own claims information, but Part A, Part B, and prescription drug claims information. That can

yield clues about lack of care coordination or beneficiaries falling through the cracks. So I think just having that information and helping providers create the management structures to see data, to understand it, to respond to data, is tremendously powerful.

For the providers that are participating within the new bundled payment initiative—the hospital, combining with physicians and post-acute—they are telling us that they had no idea that their patients were going to 10 different skilled nursing facilities, and that certain skilled nursing facilities had higher readmission rates than others. Just seeing that data, I think, is the most powerful, or one of the most powerful, changes that is occurring.

Senator CASEY. I want to ask you as well, because your testimony had a lot of analysis and summary of the way you are doing this, and it is very helpful to us as we learn more about it, but I was looking in particular on two pages of your testimony, I guess page 4 and page 8.

There are two things that struck me about the whole challenge of reducing hospital readmissions, which everyone knows is a health issue because people are sicker. When they have a readmission, that means by definition they are in some kind of jeopardy, but it also is a huge cost implication for all of us.

But on page 4, the last paragraph, you said, “The Affordable Care Act established the hospital readmission program.” Then later in the paragraph you say, “We measure the readmission rates for three very common, very expensive conditions for Medicare beneficiaries: heart attack, heart failure, and pneumonia.”

Then later on page 8, you talk about the National Partnership for Patients aiming to save 60,000 lives, which just leaps off the page, I think for anyone, and you do that by “averting millions of preventable hospital-acquired conditions.”

I wanted to get your sense of how that is going, how successful you are being at reducing the hospital readmissions. It is self-evident that it is both a better health outcome for a patient or their family as well as a huge cost saver.

Mr. BLUM. One of the things we have set as one of our primary measures for assessing how successful we are within CMS with the payment reform strategies is the rate of hospital readmissions. We track, month to month, the rate of all-cause Medicare readmissions. In the last 12 months or so, we have started to see a consistent downward trend in that number.

I think there are many policies that are being deployed—penalties, technical assistance through our Partnership for Patients—but I think one of the most powerful statements that happened is that Congress acted and said that quality of care is now being assessed through readmission rates, which has transformed the business model for health care delivery systems. I used to hear, personally, providers say it was impossible to reduce those, that there are too many community factors at play or the health care systems were not built to do this.

But now I hear that it is possible, that they are seeing results in our data. We still see tremendous variation across the country in hospital readmission rates. The current rate is roughly 17.8 percent, but there are some parts of the country that are much lower than 17.8 percent.

So we know it is possible to drive this average down further, but I think the most fundamental change that happened was that the Congress acted and said that we are going to assess quality of care in part through these readmission rates.

Senator CASEY. Well, thanks so much. I appreciate it.

Senator CARPER. Mr. Blum, how are you doing?

Mr. BLUM. Yes. It is good to see you again.

Senator CARPER. Very nice to see you. Thanks so much for coming to Delaware and for the time that you spent with us at Christiana Care.

I think it was Senator Hatch who raised the issue of SGR and trying to fix the SGR problem. I just want you to share with us, if you will, a thought or two. We hear so much from health care providers that, without a permanent solution for SGR, doctors and hospitals are not going to be able to fully participate in reforming our health care system.

I have heard it often, and I believe them, so we have a responsibility here to try to figure this out. I just want to ask you, wearing your old hat when you sat behind these guys over here and your hat today, what kind of payment policies do you think might be good candidates for replacing the existing payment system?

Mr. BLUM. Well, I agree, Senator, that the annual crisis that is created when we face the physician payment cut creates tremendous havoc for the physician community, for our beneficiaries, and for health plan payment systems that are tied to the physician payment system. It is a tremendous challenge to manage the programs through this continuously looming cut.

I think there are two ways to break down the SGR issue. The first issue is that we have an artificial baseline built into current law that continuously assumes a 25- or 28-percent cut, so, in my analysis, there is no way around that baseline correction that needs to be made to the total Medicare program that only Congress can authorize.

At the same time, the second issue is that we need to figure out continuous ways to improve how we pay for physician payments, to incent greater care coordination, and to incent chronic disease management to pay for those services that happen outside of the face-to-face interaction. We are testing a variety of models. We will continue to expand the focus to figure out how to incent this care model that I believe we all want to see, but that will not substitute for the baseline issue that Congress has to authorize.

Senator CARPER. All right. Thank you.

One of the major drivers, as you know, of health care in this country, of health care costs, is obesity. Another one is improving medication adherence. We were hearing very large numbers on both of those in terms of what they are costing us in health care.

Could you just give us an idea of what CMS is doing, (1) to combat obesity? How can we help you do a better job? Also, any comments you would care to make on improving medication adherence and how we can help you do a better job.

Mr. BLUM. One of the things that Congress did through the Affordable Care Act was add many new preventive benefit services to the traditional fee-for-service program. The annual wellness visit, I think, is one of the greatest opportunities that we have to con-

tinue to tie beneficiaries more to their primary source for primary care. The ACO program really is the same notion. So a continued emphasis on primary care and wellness, I think is our best strategy to address obesity.

We are also seeing very promising results in our Part D program as we create voluntary incentives to better manage poly-pharmacy medication management. And we are starting to see some signs that better management of prescription drugs leads to overall lower costs and hospital spending or other traditional medical spending channels. So I think more emphasis on better managing and coordinating prescription drugs is one of our best strategies to reduce total cost of care.

Senator CARPER. All right. Thank you.

The last question. Delaware is one of 10 States that has, I think, fewer than 10 percent of our Medicare population that participates in Medicare Advantage. I think in our State we really do not have any good choices, I think most people would say. That is true in some other States as well.

What should we be doing to expand Medicare Advantage in a cost-efficient way that ensures that seniors in all 50 States have a meaningful choice between high-quality Medicare Advantage plans and traditional Medicare?

Mr. BLUM. Well, I think sometimes the challenges to expand managed care—and I cannot speak for Delaware, but sometimes the challenge is not payment policy, but it is due to provider contracting. Health plans cannot establish sufficient networks because one dominant health care system might not want to contract with the health plan.

So I do not believe simply paying plans more will necessarily lead to better choices or higher quality choices. Really, sometimes you have to figure out what is happening at the provider contract level to understand why health plans cannot come into the program in a strong way.

But I think that underscores what our strategy has been, to make sure that the traditional fee-for-service program is as strong as possible and to create ACOs that really bring the best of managed care to the traditional fee-for-service program, but also to make sure that our managed care program is as strong as possible to incent plans to go to quality.

So that has been our strategy: to make sure both programs are as strong as possible so, even if beneficiaries do not choose managed care or do not have all the choices that other parts of the country have, they can still receive the same care coordination and good managed care principles that high-quality managed care plans can provide.

Senator CARPER. Thanks so much.

The CHAIRMAN. Thank you very much.

Senator Nelson?

Senator NELSON. Well, Florida is the opposite of Delaware, because upwards of 40 to 50 percent of Florida is on Medicare Advantage. So let us talk about that. Now, the insurance companies are screaming bloody murder, but should they not have known that the whole idea of the changes in Medicare Advantage was to cut out

that 14-percent bump that they had over and above Medicare fee-for-service as a result of the 2003 prescription drug bill?

Mr. BLUM. Before the Affordable Care Act, we estimated that the plan average subsidies were about 14-percent greater than fee-for-service on average. We estimate, today in 2013, that difference now is 4 percent and will be phased down even further. Many told us, and I think told this committee——

Senator NELSON. Is that 4 percent given the reductions that you have just announced or that you are planning to announce?

Mr. BLUM. That is current rates.

Senator NELSON. Oh, it is?

Mr. BLUM. So the 2014 reduction is still proposed, but today, on average, we are paying 4 percent. So the reduction has been taken from 13 percent down to 4 percent. At the same time, we have seen double-digit growth in the MA plans. We have seen double-digit decreases in the premiums.

Quality is improving, and that is a great sign that we can reduce the payment rate to incent quality and to continue to see growth in the program. We have proposed rates for 2014 that I believe you are hearing about. There are many reasons for that reduction, but again, we have proposed rates, we are listening to comments, but our goals are to ensure the program remains strong, quality continues to improve, and beneficiaries continue to have strong choices.

Senator NELSON. All right. Here is the question then: for the senior citizens, the premiums have come down, the popularity is going up, and therefore the enrollment among seniors is up because it is more popular. We are now reducing what I call the subsidy to insurance companies over and above what Medicare fee-for-service is, which was part of the reforms in the health care bill that we implemented to try to save Medicare.

In part, we were going to do that with a quality rating system called the Stars. So the theory is, the higher quality you have, the more stars you have for your plan. Seniors are going to be able to vote with their feet because they will choose the better-quality plan. That will weed out the poor plans.

What in fact is happening?

Mr. BLUM. Well, we are seeing, due to the incentive structures that have been created, many more beneficiaries choosing to be in 4-star, 5-star plans. This is happening for two reasons. One is that plans have made the business decision that they will do better if their star rating goes up. For plans that are at 4 stars, 5 stars, irrespective of payment changes over time, they will have a great financial model in the program.

Senator NELSON. So they get more people signing up in their plan the better quality they are, plus they get a financial incentive from Medicare.

Mr. BLUM. Correct.

Senator NELSON. Then why are the insurance companies screaming bloody murder, that you are squeezing out that excess that they used to have?

Mr. BLUM. Well, some plans have not yet made the transformation to 4-star, 5-star, and we want to help those plans continue to make that transformation. Our demonstration will con-

tinue in 2014, but I think those plans that are below 4 stars are facing, given our proposal—again proposed—the greatest payment challenge. But I believe that plans that have made the transformation to provide 4-star, 5-star care will have a strong business model within the Medicare program.

Senator NELSON. So your goal, to summarize, would be that you want to have all plans 4 and 5 stars, and that, if insurance companies get to that quality level, they will be making money, the senior citizen will be very happy, and the overall cost to the taxpayer is lower. Is that the goal?

Mr. BLUM. That is precisely the goal. Our goal is for every Medicare beneficiary who chooses the MA program to have the opportunity to seek out a 4- or 5-star plan.

Senator NELSON. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Casey?

Senator CASEY. I had my round. I am good.

The CHAIRMAN. Good.

Senator CASEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thanks, everyone. Thanks, Mr. Blum. Clearly you are making progress. Clearly we have a lot more progress ahead of us, but thank you very much.

Mr. BLUM. Thank you, Senator.

The CHAIRMAN. And if you could get back to us soon about interim information, that would be helpful.

Mr. BLUM. Absolutely.

The CHAIRMAN. Thank you very much.

[Whereupon, at 12 p.m., the hearing was concluded.]

A P P E N D I X

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Hearing Statement of Senator Max Baucus (D-Mont.) On Making Medicare and Medicaid More Efficient and Affordable

President Abraham Lincoln once said, "The best way to predict your future is to create it."

In 2009, we didn't like the future we saw for a health care system based on a fee-for-service payment model. Doctors and hospitals were getting paid for the amount of care delivered, instead of how well they delivered care to patients.

So in the Affordable Care Act, we created new and better ways to deliver health care, save taxpayer dollars and improve patient care.

Medicare and Medicaid, in partnership with the private sector, are now working to create the roadmap for the future of health care delivery. And we're here today to make sure they're on the right track.

Since we enacted the Affordable Care Act, health care spending has grown at the lowest rate in the 52 years since records have been kept.

According to the Congressional Budget Office, spending on Medicare and Medicaid last year was five percent lower than they predicted just two years before.

And by 2020, spending on both programs is projected to be 15 percent less than originally anticipated.

There's a clear slowdown in health care spending. But we need to do more, and do it faster, to change the way Medicare and Medicaid pay for health care.

At a hearing I held on Tuesday on how to boost the country's economic outlook, we heard from leading economists Douglas Holtz-Eakin and Bob Greenstein that the number one way to reduce health care spending is to end fee for service.

Everyone agrees that fee for service drives volume, excess, and waste. We know this way of paying for health care encourages the wrong things. That's why health reform changed the incentives for providers. And Medicare and Medicaid are testing different programs to determine which work best.

In October, Medicare rolled out a program with a simple yet revolutionary premise. Medicare is going to pay hospitals to get the job done right the first time. Hospitals are penalized if patients are readmitted too soon after being discharged.

Communities from Montana to Maryland are rising to the challenge. In Missoula, Montana, the local aging services agency is partnering with Medicare on care transitions.

Under this program, patients at high risk for readmissions to one of the two local hospitals in Missoula will get extra help making the transition from the hospital back into the community.

Today we will hear about new data showing a significant first step in bending the curve on Medicare hospital readmissions.

The rate for Medicare patients returning to the hospital for treatment has fallen by more than a full percent over the past several months after being firmly stuck for years or decades.

Medicare and Medicaid also implemented a new program in October that pays hospitals more for delivering better care and penalizes them financially for poor outcomes.

For those outside of health care, this idea will not sound revolutionary. It makes sense.

When you take your car to the repair shop to get the brakes fixed and they break the windshield, you shouldn't have to pay for the broken windshield.

Starting in October, hospitals can be penalized if you go in with a heart attack and the hospital is responsible for giving you a surgical infection. And hospitals can be rewarded for good customer service and patient care.

That means doctors and nurses share information and tests, explain medications, and develop a plan of coordinated care for a patient leaving a hospital.

We need to get more value out of each taxpayer dollar spent. But we also need to help providers work better together and coordinate care. Medicare and Medicaid need to reimburse hospitals, doctors, and nursing homes to keep patients healthy. Accountable Care Organizations are starting to make this happen.

In Medicare, almost 300 Accountable Care Organizations – including in Billings, Montana – have teamed up to serve more than four million beneficiaries.

In these organizations, doctors, hospitals, and other providers work together to give patients coordinated care. The providers make talking to each other a priority, and they work to ensure patients get the right care at the right time.

Medicaid has also come to the table to provide new solutions to the cost challenges facing states. Medicaid beneficiaries in Minnesota will be among the first to participate in a new Integrated Care Model that will link patient outcomes and experience to payments. Providers will be held accountable by sharing in the savings and losses for the total cost of care.

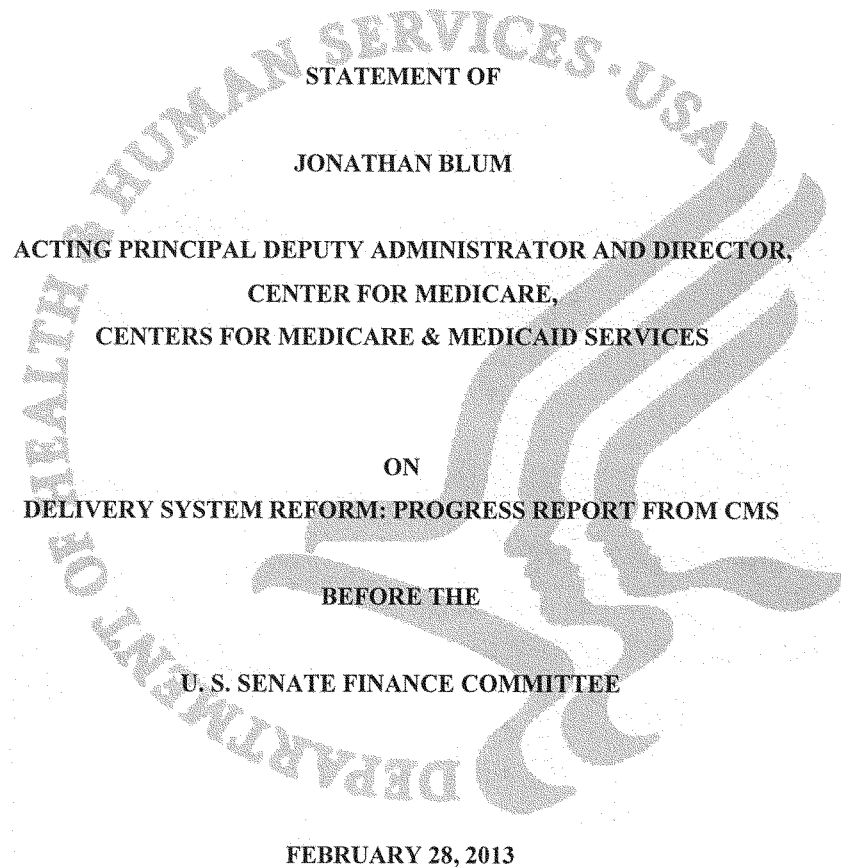
My state of Montana started a program to lower diabetes and cardiovascular disease in its Medicaid population. The goal is to help participants lose weight and keep it off, which makes them healthier and reduces costs in the Medicaid program.

We need Medicare and Medicaid to support these state efforts and offer flexibility to test innovative ideas.

I look forward to examining the progress Medicare and Medicaid have made, learning what has worked, and finding ways we can do more quickly.

So let us listen to President Lincoln and realize that we are in charge of creating our future, let us do more to lower costs and improve quality within Medicare and Medicaid, and let us create the future of health care delivery.

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STATEMENT OF

JONATHAN BLUM

ACTING PRINCIPAL DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR MEDICARE,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

DELIVERY SYSTEM REFORM: PROGRESS REPORT FROM CMS

BEFORE THE

U. S. SENATE FINANCE COMMITTEE

FEBRUARY 28, 2013

Statement of Jonathan Blum on
Delivery System Reform: Progress Report from CMS
Senate Committee on Finance
February 28, 2013

Chairman Baucus, Ranking Member Hatch, and members of the Committee, thank you for this opportunity to highlight the efforts of the Centers for Medicare & Medicaid Services (CMS) to strengthen the Medicare program and improve our health care delivery system. Since the passage of the Affordable Care Act nearly three years ago, CMS has worked tirelessly to implement the reforms to the health care delivery system envisioned by Congress and your Committee. While work remains to be done, I am pleased to report that we are making significant progress on transforming the Medicare program and promoting quality nationwide.

The Affordable Care Act included important reforms to improve the quality of health care for Medicare and Medicaid beneficiaries and, in doing so, lower costs for taxpayers and patients. These reforms include incentives and tools to help providers avoid costly mistakes and readmissions, keep patients healthy, and make sure Medicare and Medicaid payments reward excellent care and not simply the provision of more low-value services. In addition, a number of reforms promoted by this Administration, including competitive bidding programs, change how we approach waste, fraud and abuse and improving the accuracy of our payments. These payment changes and investments will strengthen our health care system, ensuring quality care for generations to come – not just for Medicare and Medicaid beneficiaries, but for all patients that depend on our health care system.

Medicare beneficiaries are already starting to enjoy better quality of care through innovative care delivery systems designed to improve their health outcomes and reduce costs. Affordable Care Act reforms are contributing substantially to recent reductions in the growth rate of Medicare spending per beneficiary¹ without reducing benefits for beneficiaries. Growth in national health expenditures over the past three years was lower than any time over the last 50 years. Fraud recoveries have increased to a record \$4.2 billion in 2012, and \$14.9 billion over

¹ ASPE Issue Brief: “*Growth In Medicare Spending Per Beneficiary Continues To Hit Historic Lows*” for full report please visit: <http://aspe.hhs.gov/health/reports/2013/medicarependinggrowth/ib.cfm>

the last four years. Medicare beneficiaries have gained access to additional benefits, such as increased coverage of preventive services and lower cost-sharing for prescription drugs.

We are also observing a decrease in the rate of patients returning to the hospital after being discharged. After fluctuating between 18.5 percent and 19.5 percent for the past five years, the 30-day all-cause readmission rate dropped to 17.8 percent in the final quarter of 2012. This decrease is an early sign that our payment and delivery reforms are having an impact.

The Affordable Care Act tied payment to private Medicare Advantage plans to the quality of coverage they offer for the first time. Since those payment changes went into effect, seniors have been able to choose from a broader range of Medicare Advantage plans, and more seniors have enrolled in higher-rated plans.

People with Medicare will have access to 127 four and five-star Medicare Advantage plans, 21 more top-performing plans than the previous year. Additionally, 30 percent of stand-alone prescription drug plans available to beneficiaries received a star rating of 4 or higher. More than 37 percent of Medicare Advantage enrollees are now enrolled in a four- or five-star plan.

Growing numbers of physicians and other providers are participating in new payment initiatives that reward higher-quality and lower-cost care. In 2012, we launched the first cohort of Medicare Accountable Care Organizations (ACOs), groups of providers working together to promote accountability for a patient population and redesigning care processes for high quality and efficient service delivery. To date, more than 250 Medicare ACOs are in operation, available in almost every State. CMS estimates that these organizations serve about four million Medicare beneficiaries.

Moving Away from a Delivery System that is Fragmented and Expensive

These early successes are occurring in the face of historical challenges in the current health care delivery system. Our nation enjoys access to world-class physicians and health care systems, and the United States leads the world in health care technology and cutting edge treatments. Yet the system in which these talented people work falls short far too often. Our delivery system is

often fragmented, leaving patients in the care of multiple doctors, each sometimes unaware of how the other is treating the patient. Furthermore, our data demonstrate that there is little apparent relationship between the cost a payer pays for care and the quality of the care a patient receives. Medicare spending per person varies widely throughout the country.²

To begin to address these longstanding challenges, CMS is implementing initiatives to encourage health care providers to deliver high-quality, coordinated care at lower costs. These reforms are enabling us to pay for value, not simply the quantity of care provided, while promoting patient safety and seeing that care is better coordinated across the health care delivery system. CMS has also implemented a number of reforms to crack-down on fraud and ensure that payments are accurate. In effect, the Medicare program has been transformed from a passive payer of services into an active purchaser of high-quality, affordable care.

The Affordable Care Act provided CMS with valuable tools to help us research and demonstrate care improvements and lower costs through the creation of the Center for Medicare and Medicaid Innovation (CMS Innovation Center). The CMS Innovation Center is focused on testing new payment and service delivery models, evaluating results and advancing best practices, and engaging a broad range of stakeholders to develop additional models for testing.

The CMS Innovation Center enables CMS to quickly and efficiently develop models and expand those that prove successful at reducing program expenditures while preserving or enhancing quality of care. Some of the models being tested by the CMS Innovation Center include efforts to reduce unnecessary hospital admissions among residents of nursing homes; improve care coordination for beneficiaries with end-stage renal disease (ESRD); decrease premature births; and incentivize primary care providers to offer high-quality, coordinated care. While the work of the CMS Innovation Center tests many payment and service delivery models, these initiatives are only a part of our efforts to build a health care delivery system that will better serve all Americans.

² Centers for Medicare & Medicaid Services (2011). *Health Expenditures by State of Residence*. Retrieved (December 2011) at <http://www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip>.

Paying for Value

We know that when Medicare bases its payments solely on the number of services provided and not on the quality of care, beneficiaries may receive duplicative tests or services that may not improve their health. CMS has launched several initiatives to more closely link payments with quality outcomes and promote value-based care. Value-based health care relies on the concept that buyers should hold providers of health care accountable for both cost and quality of care.

Improving Quality in the Hospital Setting

CMS has implemented two programs to strengthen incentives to improve the quality of inpatient care provided to Medicare beneficiaries enrolled in the traditional fee-for-service program.

First, as required by the Affordable Care Act, beginning in October 2012, Medicare began adjusting payments to acute care hospitals according to how well they meet Medicare's quality standards. These standards are consistent with evidence-based clinical practice for the provision of high quality care. Hospitals are scored on improvement as well as achievement on a variety of quality measures. The higher a hospital's performance score during a performance period, the higher the hospital's value-based incentive payment will be for a subsequent fiscal year. The Hospital Value-Based Purchasing Program is a carefully crafted program that incorporated significant stakeholder feedback. The Hospital VBP Program will redistribute an estimated \$963 million to hospitals based on their quality performance in the FY 2013 payment year.

Second, the Affordable Care Act established the Hospital Readmissions Reduction Program, which reduces Medicare payments to hospitals that have high rates of readmissions beginning in October 2012. Currently, we measure the readmissions rates for three very common and very expensive conditions for Medicare beneficiaries—heart attack, heart failure, and pneumonia. We publish hospital performance on these measures on our website. Beginning in fiscal year 2015, we will have the authority to expand the program so that additional measures could be included, and we expect that the program will have an even greater impact. Though the payment adjustments took effect only recently, hospitals have been preparing for this program for some time and results suggest it is already having a positive impact. After five years of relative

stability, the Medicare readmissions rate began to drop across the country in the final quarter of 2012.

Value-Based Payments for Physicians

The Affordable Care Act also required CMS to develop a physician value-based payment modifier and apply it to all physicians and groups of physicians by 2017. The value modifier is an adjustment to payments under the Physician Fee Schedule based upon the quality of care furnished compared to cost. CMS will begin to apply the value modifier to groups of physicians, starting with groups of 100 or more eligible professionals in 2015 based upon performance during calendar year 2013.

To help physicians understand how their payment could be affected by the value modifier, in December 2012, CMS made available approximately 95,000 quality and resource use reports to individual physicians practicing in groups of 25 or more in nine States.³ Later this year, CMS plans to provide all groups of physicians with at least 25 eligible professionals a report on the quality and cost of care they provide and showing how their payment could be affected by the value modifier.

Strengthening Medicare Advantage through Quality Improvement

A high-quality, successful Medicare Advantage Program is an important part of our health care delivery system. With this in mind, CMS is committed to making Medicare Advantage quality, performance, and other data widely available so beneficiaries can choose a plan that best meets their individual health care needs. Nearly 100 percent of Medicare beneficiaries enjoy access to a Medicare Advantage plan. In 2013, on average, there are 26 Medicare Advantage plans to choose from in each county. Since 2010 when the Affordable Care Act was passed, Medicare Advantage premiums on average have fallen 10 percent and enrollment has climbed by an expected 28 percent by the end of this year.

³ Note: The nine States are California, Illinois, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, and Wisconsin.

To help promote value in the Medicare Advantage program, CMS created the Medicare Plan Ratings – a five star system to quantify the quality and performance of Medicare Advantage plans. The Affordable Care Act expanded the use of star ratings, linking the ratings with payment, and requiring CMS to award bonus payments to Medicare Advantage plans with at least four stars beginning in 2012.

CMS has built on this bonus system through the Medicare Advantage Quality Bonus Payment Demonstration, which began on January 1, 2012. Under the Affordable Care Act's structure, five star plans receive the same quality bonus incentive payments as four star plans, but under the temporary demonstration in effect, better performing plans receive a higher bonus. For the 2013 plan year, people with Medicare had access to 127 five- and four-star plans, 21 more top-performing plans than the previous year. Overall, the average plan star rating has also improved. The raise in ratings suggests plans are motivated to improve further under the demonstration, thereby providing higher quality outcomes to beneficiaries and greater value to the Medicare program.

This investment in Medicare Advantage quality is already paying dividends, with more beneficiaries selecting high quality plans. An independent analysis by Medicare Payment Advisory Commission (MedPAC) staff⁴ shows that the share of Medicare Advantage plans with higher quality ratings has increased since the program began. Additional research has shown that the higher the quality ranking, the more likely it is that a beneficiary will enroll in a specific program.⁵ From 2009 to 2012, the percentage of Medicare Advantage beneficiaries enrolled in four- or five-star plans has increased from 16 percent in 2009 to 37 percent in 2012.

Bundled Payments

CMS recently launched the Bundled Payments for Care Improvement initiative, a new payment model developed by the CMS Innovation Center. Traditionally, Medicare makes separate payments to providers for each of the individual services they furnish to beneficiaries for a single

⁴ MedPAC Staff Briefing: "*The Medicare Advantage program: Status report; recommendations on special needs plans*" <http://www.medpac.gov/transcripts/MA%200113%20Presentation%20public.pdf> (Page 8)

⁵ Journal of American Medical Association: "*Association Between Medicare Advantage Plan Star Ratings and Enrollment*" <http://media.jamanetwork.com/news-item/higher-quality-rating-for-medicare-advantage-plan-associated-with-increased-likelihood-of-plan-enrollment/>

illness or course of treatment. This approach can result in fragmented care and a lack of coordination across health care settings. Research has shown that bundled payments can align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners– allowing them to work closely together across all specialties and settings.⁶

The Bundled Payments for Care Improvement initiative is composed of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care. Over the course of the three-year initiative, CMS will work with participating organizations to assess whether the models being tested result in improved patient care and lower costs to Medicare.

Improving Quality in Dialysis Facilities

An End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) ties Medicare payments directly to facility performance on quality measures, resulting in better care at lower cost for nearly 500,000 Americans with kidney disease. Over the past 35 years, CMS has instituted a series of quality initiatives to improve dialysis care. The ESRD QIP is mandated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and is the nation's first pay-for-performance QIP. This first-of-its-kind program provides the ESRD community with the opportunity to enhance the overall quality of care that ESRD patients receive as they battle this devastating disease.

And this month, CMS announced the Comprehensive ESRD Care Initiative, a new model from the Innovation Center that will provide incentives for dialysis centers, nephrologists, and others to work together to improve not just dialysis, but the entire care experience for ESRD patients. Through this new initiative, CMS will partner with groups of health care providers and suppliers – ESRD Seamless Care Organizations (ESCOs) – to test and evaluate a new model of payment

⁶ Cromwell J., Dayhoff DA., McCall NT, et al. Medicare Participating Heart Bypass Center Demonstration: Final Report. Prepared by Health Economics Research, Inc. 1998.

Abt Associates, Inc., Medicare Cataract Surgery Alternate Payment Demonstration: Final Evaluation Report, Cambridge, Mass: Abt Associates, Inc; 1997.

Casale A.S. et al. ProvenCare: A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care, *Annals of Surgery*. 2007;(246) 4:613-621.

Medicare Acute Care Episode Demonstration.

<http://www.cms.gov/DemoProjectsEvalRpts/downloads/ACESolicitation.pdf>.

and care delivery specific to Medicare beneficiaries with ESRD. Participating ESCOs will be clinically and financially responsible for all care offered to its patients, not only dialysis care or care specifically related to a beneficiary's ESRD.

Protecting Patient Safety and Promoting Better Care

In addition to promoting value, we are also striving to make the health care system safer for patients. Medical errors can occur as a patient moves from one care setting to another, or is prescribed different medications with potentially dangerous interactions. Better coordination among doctors and specialists and across health care settings protects patients from errors while also reducing unnecessary duplication. CMS has undertaken several efforts to promote better care and improve patient safety. These programs focus on assisting health care providers in delivering coordinated, high quality care to their patients. These programs not only will help save money for patients and taxpayers, but we believe they will save lives.

Partnership for Patients

The nationwide Partnership for Patients initiative aims to save 60,000 lives by averting millions of preventable hospital-acquired conditions (HACs) and reducing preventable hospital readmissions over the next three years, while providing savings to Medicare and Medicaid by reducing complications and readmissions during the transition from one care setting to another. Over 3,700 hospitals, as well as physicians' and nurses' organizations, consumer groups, employers, and other major stakeholders, have pledged to help achieve the Partnership's goals. Additionally, 26 Hospital Engagement Networks, which work at the National, regional, State, or hospital system levels, are identifying best practices and solutions in reducing HACs and readmissions and disseminating information to health care providers and institutions, nationwide. Examples include preventing adverse drug reactions, pressure ulcers, premature deliveries, childbirth complications, and surgical site infections.

The Community-based Care Transition Program, also part of the Partnership for Patients, supports 82 participant organizations working in partnership with Community Based Organizations in 33 States to help high-risk Medicare beneficiaries make successful transitions

from hospital to home or to another post-hospital setting. Hospitals are a logical focal point for efforts to reduce readmissions, since the quality of care during a hospitalization and the discharge planning process can have an impact on whether a patient will continue to heal or return. However, it is clear that there are multiple factors along the care continuum that affect readmissions. The Community-based Care Transition Program helps identify the key drivers of readmissions for a hospital and its downstream providers, taking the first step towards implementing the appropriate interventions necessary for reducing readmissions.

Additional Efforts to Increase Patient Safety

The Partnership for Patients builds on other CMS efforts to leverage payment policy in support of patient safety. Since 2008, CMS has eliminated additional payment for HACs (cases in which certain conditions were not present on admission).

In 2012, CMS added additional HACs to the list of conditions that would warrant CMS eliminating additional payments.⁷ While Medicare pays hospitals the standard rates for the original admission, we no longer pay hospitals for the additional costs associated with the care and treatment of these HACs. To further reduce HACs and improve patient quality, starting in FY 2015, hospitals with high overall rates of HACs will see their payments reduced. CMS has issued similar guidelines for Medicaid.

CMS created the Hospital Compare Website⁸ to promote transparency and to better inform health care consumers about a hospital's quality of care. This tool shows a hospital's performance on a wide variety of quality measures, including certain measures of healthcare infections. In the coming years, additional measures will be added to the Hospital Compare website, making this an even richer source of information for consumers.

⁷ A complete list of HAC categories and their corresponding complication or comorbidity (CC) or major complication or comorbidity (MCC) codes finalized for FY 2013 can be found at: <http://www.cms.gov/Medicare/Medicare-fee-for-service-Payment/HospitalAcqCond/Downloads/HACFactsheet.pdf>

⁸ For more information on the Hospital Compare Website please visit: <http://www.medicare.gov/hospitalcompare>

Accountable Care Organizations

Accountable Care Organizations (ACOs) are one of the Affordable Care Act's key reforms to improve the delivery of care. ACOs are groups of doctors and other health care providers that have agreed to work together to treat individual patients and better coordinate their care across care settings. They share—with Medicare—any savings generated from lowering the growth in health care costs while improving quality of care including providing patient-centered care.

In just over a year, over 250 ACOs were formed and are working to improve the care experience for more than four million Medicare fee-for-service beneficiaries nationwide. This is approximately eight percent of all beneficiaries in the Medicare program, and will grow over time as existing ACOs choose to add providers and more organizations are approved for participation in the program. They are located in 47 States and territories—from the most remote community in Montana to as far away as Puerto Rico.

The new ACOs include a diverse cross-section of physician practices across the country. Roughly half of all ACOs are physician-led organizations that serve fewer than 10,000 beneficiaries. Approximately 20 percent of ACOs include community health centers, rural health clinics and critical access hospitals that serve low-income and rural communities. Participation in an ACO is purely voluntary for providers, and we will accept applications annually for the Shared Savings Program to allow more providers to come together and work to improve the quality and cost efficiency of care our Medicare FFS beneficiaries receive.

The Shared Savings Program requires that participants—which can be providers, hospitals, suppliers, and others—coordinate care for all services provided under Medicare FFS and encourages investment in infrastructure and redesigned care processes. ACOs that lower their growth in health care costs, while also meeting clearly defined performance standards on health care quality, are eligible keep a portion of the savings they generate for the program. As a result of these efforts we are seeing providers developing strategies to work together to redesign care process, promote preventive care, and better coordinate services for patients with chronic disease and high risk individuals.

In addition to the ACOs participating in the Shared Savings Program, the CMS Innovation Center is testing a different payment model for ACOs, the Pioneer ACO model. The Pioneer ACO model is designed for health care organizations that have experience coordinating care for patients across care settings. This model tests alternative payment models that include escalating levels of financial accountability. One purpose of the Pioneer ACO model is to inform future changes to the Shared Savings Program. Thirty-two organizations are participating in the testing of the Pioneer ACO model.

The Innovation Center is also testing the Advance Payment ACO model. The Advance Payment ACO model examines whether and how pre-paying a portion of future shared savings could increase participation in the Shared Savings Program from entities such as physician-owned and rural providers with less capital. Through the Advance Payment ACO Model, selected participants receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure. It is our hope that the assistance the Advanced Payment Model provides to smaller and rural practices will result in expanding access to this coordinated care effort to more fee-for-service Medicare beneficiaries. Currently 35 ACOs are participating in this model.

Comprehensive Primary Care Initiative

CMS is also working to strengthen primary care by improving care coordination. Approximately 500 primary care practices⁹ in 7 markets are participating in the Comprehensive Primary Care initiative- a multi-payer model testing the effectiveness of enhanced payments to primary care practices in improving care coordination for people enrolled in Medicare and Medicaid. CMS consulted extensively with other payers to design a model that would be suitable for adoption by Medicare, commercial, and Medicaid payers.

Under this initiative, primary care practices are given the resources they need to transform their practices to better serve their patients, such as developing care plans and using a team based approach to care. Participating practices receive an additional payment from CMS and are

⁹ For a full list of participating practices please visit: <https://data.cms.gov/Government/CPC-Initiative-Participating-Primary-Care-Practice/mw5h-fu5i>

eligible for shared savings beginning in the second year of the initiative, in addition to enhanced payment the practice might receive from other payers.

Coordination of Care for Medicare-Medicaid Enrollees

CMS is also focused on the coordination of care for those individuals who qualify for both the Medicare and Medicaid programs. While Medicare and Medicaid are separate programs, a growing number of people—known as Medicare-Medicaid enrollees or dual eligibles—depend on both programs for their care. To meet their needs effectively, both programs need to work together.

Today, more than 10 million Americans¹⁰ are enrolled in both the Medicare and Medicaid programs; nearly two-thirds are low-income elderly and one-third are people who are under age 65 with disabilities. In many cases, they are among the poorest and sickest people covered by either program.¹¹

Currently, the majority of Medicare-Medicaid enrollees must navigate three sets of rules and coverage requirements (Medicare fee-for-service, a Medicare prescription drug plan, and Medicaid) and manage multiple identification cards, benefits, and plans. As a result of this lack of coordination, care often is fragmented or episodic, which can result in poor health outcomes for a population with complex needs. It also leads to misaligned incentives for payers and providers, resulting in cost-shifting, unnecessary spending and an inefficient system of care.

Under the Affordable Care Act, Congress established the Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office (MMCO), to more effectively integrate Medicare and Medicaid benefits and improve the coordination between the Federal and State governments for this vulnerable population. We are continuing to make progress in our efforts to create a more streamlined system that delivers quality, cost-effective care. Among

¹⁰ Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011, Prepared by the Medicare-Medicaid Coordination Office, February 2013 http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf

¹¹ Kaiser Family Foundation, Medicaid's Role for Low-Income Medicare Beneficiaries, May 2011 Report *available at* <http://www.kff.org/medicaid/upload/4091-08.pdf>; Kaiser Family Foundation.

them, CMS has announced agreements with Ohio, Massachusetts, Washington, and Illinois to test new models to better align the Medicare and Medicaid programs. We have undertaken numerous initiatives to further our work to improve care coordination and quality of care for Medicare-Medicaid enrollees, including developing new tools to gain a better understanding of the population, increasing States' access to Medicare data for their Medicare-Medicaid enrollees, and partnering with organizations to reduce avoidable hospitalizations.¹² I know the Committee heard from my colleague Melanie Bella in December on the important work of the Medicare-Medicaid Coordination Office.

Electronic Health Records

The American Recovery and Reinvestment Act of 2009 provided support to physicians and other providers who adopt electronic health records. These electronic health record systems are making it easier for physicians, hospitals, and others serving Medicare and Medicaid beneficiaries to evaluate patients' medical status, eliminate redundant and costly procedures, and provide high-quality care. More than 185,000 eligible health care professionals—roughly one-third—and over 3,500 eligible hospitals—roughly two-thirds—have already qualified for incentive payments. These investments in electronic health records will help speed the adoption of many other delivery system reforms, by making it easier for hospitals and doctors to better coordinate care.

Improving Physician Payments

While we must all work together to address the long-term imbalance of the Sustainable Growth Rate, CMS has made important strides to improve the accuracy of our physician payment system and to emphasize the value of primary care in our physician fee schedule. Through the misvalued code initiative, CMS has taken a much more aggressive stance in updating payment codes that are over-valued. CMS has added new payment codes to pay for care transitions, recognizing the value that results from coordinated care following a hospital admission. And we

¹² For more information on CMS's agreements with Ohio, Washington, and Massachusetts and other States' proposals, please visit: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html>

have also implemented enhanced payments for primary care visits, consistent with the Affordable Care Act.

Payment Accuracy

Ensuring payment accuracy is another vital piece of our efforts to control the growth of Medicare costs. Preventing errors, fraud and other waste in our programs preserves scarce resources that can be better invested in efforts to improve health care. Over the last two years, CMS has implemented powerful new anti-fraud tools provided by Congress, as well as designed and implemented large-scale, innovative improvements to our Medicare and Medicaid program integrity strategy to shift beyond a “pay-and-chase” approach by focusing new attention on preventing fraud. Simultaneously, CMS is using the same innovative tools to strengthen our collaboration with our law enforcement partners in detecting and preventing fraud. The Administration’s efforts are paying off, with a record \$4.2 billion in fraud recoveries collected in 2012, totaling \$14.9 billion over the last four years.

Every workday, Medicare pays out more than \$1 billion from some 4.6 million claims, and is statutorily required to pay claims quickly, usually within 14 to 30 days. Medicaid is administered by States within the bounds of Federal law, and CMS partners with each State Medicaid program to support program integrity efforts. The 56 separate State-run Medicaid programs process 4.4 million claims per day. Preventing fraud in Medicare and Medicaid involves striking an important balance: protecting beneficiary access to necessary health care services and reducing the administrative burden on legitimate providers, while ensuring that taxpayer dollars are not lost to fraud, waste, and abuse.

Building upon traditional program integrity efforts to detect and prosecute fraud, CMS has implemented a “twin-pillar” approach to fraud prevention in Medicare. The first pillar is the new Fraud Prevention System (FPS), which applies predictive analytic technology to incoming claims prior to payment to identify aberrant and suspicious billing patterns. The second pillar is the Automated Provider Screening (APS) system, which is designed to identify ineligible providers or suppliers prior to their enrollment or revalidation. Since March 2011, CMS validated or revalidated enrollment information for nearly 410,000 Medicare providers and suppliers under

the enhanced screening requirements of the Affordable Care Act. Because of revalidation and other proactive initiatives, CMS has deactivated 136,682 enrollments and revoked 12,447 enrollments. Together these innovative new systems, the FPS and APS, are growing in their capacity to protect patients and taxpayers from those intent on defrauding our programs. CMS is evaluating many of the tools used in Medicare for opportunities to transfer the knowledge and lessons learned to the Medicaid program.

In addition, CMS implemented a demonstration that requires prior authorization for power mobility devices (PMDs) for beneficiaries who reside in seven States¹³ with high incidence of fraud and improper payments. It is designed to develop and demonstrate improved methods for the investigation and prosecution of fraud associated with these items. Through the use of prior authorization, this demonstration will also help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. Most important, the program will assist in preserving a Medicare beneficiary's ability to receive quality products from accredited suppliers.

We are also working to implement and expand competitive bidding for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) which enables the Medicare program to pay a fairer and more accurate price for equipment used by beneficiaries. In the past, Medicare has paid for DMEPOS items using a fee schedule that is generally based on historic supplier charges from the 1980s. Numerous studies from the Department of Health and Human Services Office of Inspector General and the Government Accountability Office have shown these fee schedule prices to be excessive, and taxpayers and Medicare beneficiaries bear the burden of these excessive payments.¹⁴

Under the DMEPOS Competitive Bidding Program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding

¹³ The seven States in the demonstration are California, Illinois, Michigan, New York, North Carolina, Florida and Texas.

¹⁴ See, for example, *Comparison of Prices for Negative Pressure Wound Therapy Pumps*, OEI-02-07-00660, March 2009; *Power Wheelchairs in the Medicare Program: Supplier Acquisition Costs and Services*, OEI-04-07-00400, August 2009; *Medicare Home Oxygen Equipment: Cost and Servicing*, OEI-09-04-00420, September 2006.

areas. The new, lower payment amounts resulting from the competition replaces the fee schedule amounts for the bid items in these areas. The CMS Office of the Actuary estimated that the program would save the Medicare Part B Trust Fund \$26.2 billion and beneficiaries \$17 billion between 2013 and 2023.

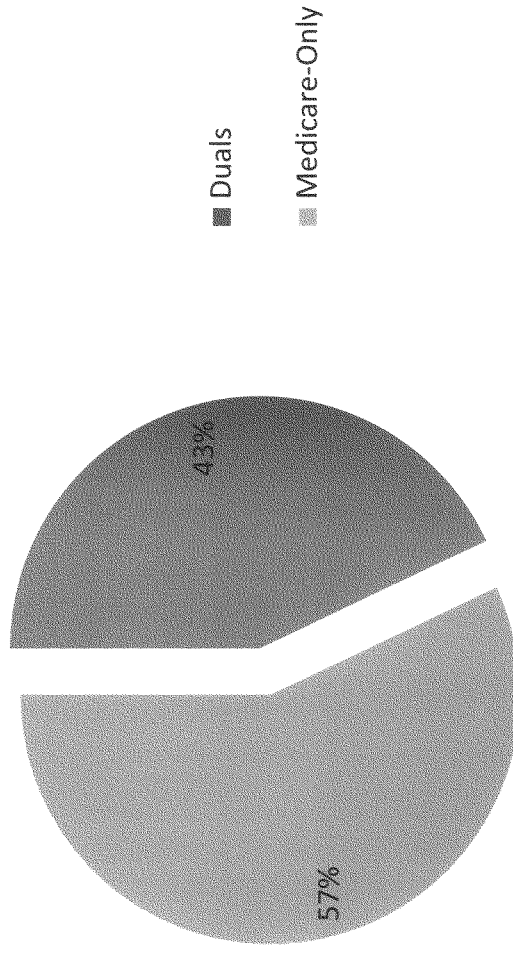
The first round of the DMEPOS Competitive Bidding Program went into effect in nine areas of the country on January 1, 2011. In January 2012, CMS initiated bidding for a major expansion of the DMEPOS Competitive Bidding Program in Round 2, which will result in the application of competitively-bid prices in far more areas across the country, saving money for beneficiaries and taxpayers. Round 2 is scheduled to go into effect in 91 major metropolitan areas on July 1, 2013 and is projected to result in average price reductions of 45 percent as compared to the current fee schedule prices. The payment amounts for a new competitively-bid national mail-order program for diabetic testing supplies that is being implemented for both retail and mail-order suppliers at the same time as Round 2 are projected to result in average savings of 72 percent. The national mail-order competition will include all parts of the United States, including the 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

Conclusion

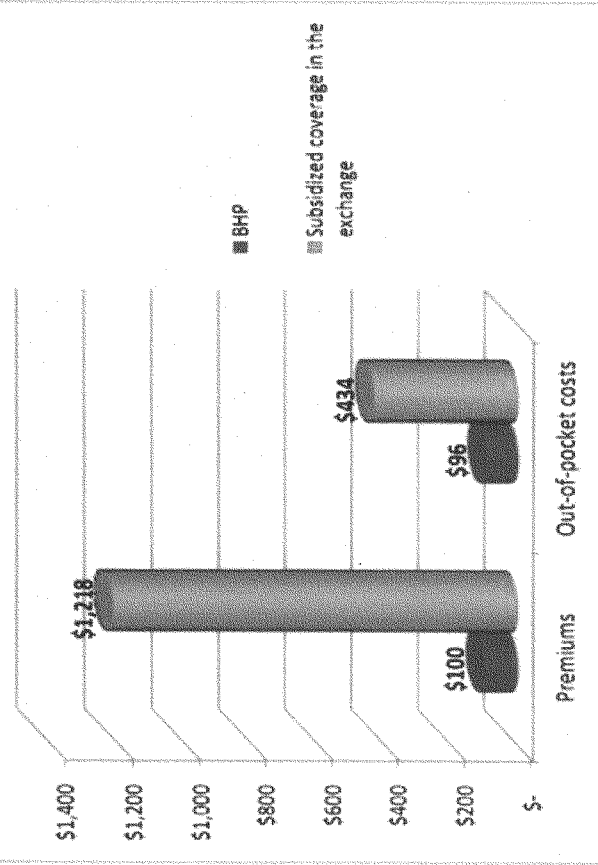
CMS has taken the charge that this Committee and Congress gave to us to reform our nation's health care delivery system very seriously. The Agency has been working diligently to implement the changes and innovations included in the Affordable Care Act in a timely manner and has already made real progress, demonstrated by decreasing readmissions to hospitals and a reduced growth in Medicare costs. It is important to remember that these changes help not only Medicare beneficiaries, but all patients across the health care delivery system. As hospitals take action to prevent infections and lower the rate of preventable readmissions, all hospital patients will benefit from safer care. However, more work remains to be done to make Medicare sustainable for the long-term and improve the overall delivery of care. We look forward to working with this Committee to continue to reduce health spending and increase care quality for patients.

Are Duals The Only High Cost Beneficiaries?

Among the Highest Cost Medicare Beneficiaries

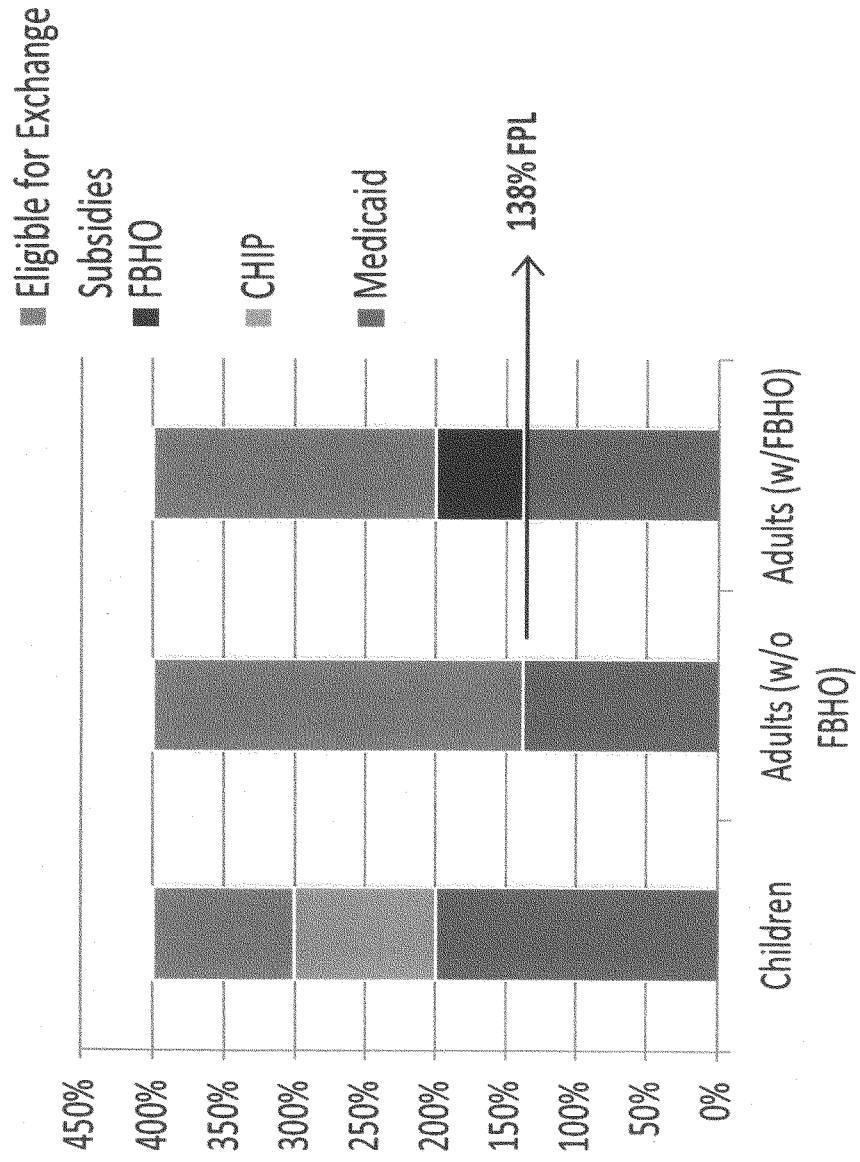


Annual Costs: Basic Health vs. Exchange



Source: HIPSM 2011. Note: Results show effects as if policies were fully implemented in 2011.

<http://www.urban.org/uploadedpdf/412412-Using-the-Basic-Health-Program-to-Make-Coverage-More-Affordable-to-Low-Income-Households.pdf>



**STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER
U.S. SENATE COMMITTEE ON FINANCE HEARING OF FEBRUARY 28, 2013
DELIVERY SYSTEM REFORM: PROGRESS REPORT FROM CMS**

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, delivered the following opening statement at a committee hearing examining the progress of health care delivery system reforms in the nation:

I want to thank Senator Baucus for convening this timely and much needed hearing this morning.

Last week, Time Magazine ran a thought-provoking article. It was, in fact, the longest article in the publication's history. It was an exploration of the high cost of medical care in this country and what those costs mean for patients.

It was a fascinating article, and, it got me thinking.

Over the last five years, we've spent a lot of time here in Congress talking about health care. Obamacare was signed into law nearly three years ago and was supposed to make health care more affordable for patients and consumers. Now, Obamacare did a lot of things, but, as far as I can tell, it has done very little to address the biggest health-related concern that people have – the actual cost of care.

I hope that, at some point, we can take a serious look at the drivers of healthcare costs in the U.S. I think it would be well worth the committee's time.

Today, however, we are here for a different reason.

The Finance Committee held a hearing last year wherein we heard from providers and third-party payers in the private sector who have come together to do some interesting things to try to improve care while reducing costs. While I believe the private sector can and will make great strides in this area, we cannot forget that Medicare is the nation's largest healthcare payer. That being the case, if we're serious about reducing costs, our efforts to encourage innovation must include Medicare.

Now, I have been very clear about my opposition to Obamacare. My concerns about the adverse impact of this law on family premiums and our national health spending continue to grow with every passing day. However, the Chairman and I agree that healthcare providers and payers – of all shapes and sizes – need to work together to provide patients with higher-quality, better coordinated care.

According to the Medicare Payment Advisory Commission's most recent report, in 2010, individuals, government, and businesses spent a total of \$2.6 trillion on health care.

Today, about 45 percent of all health care spending comes from government. And, in 2014 when the Medicaid expansions begin, that share will rise to 50 percent. The Congressional Budget Office projects that by 2021 – just eight years from now – spending on Medicare and Medicaid will grow to \$1.6 trillion.

By virtue of its sheer size, Medicare has an important influence on the overall health care delivery in our country. Clearly, with the right policies in place, Medicare can be a driver of change. That being said, I also question whether the program can be as nimble as the private sector in making systemic improvements.

Mr. Blum, I hope that you will be able to reassure us that it can be.

As most health care providers will tell you, in addition to the rapid aging of our population, we have to contend with increasing number of patients with chronic illnesses, such as diabetes or heart disease. These patients are sicker and more expensive to treat. And, while providers are doing their best to manage these patients, often times, our health care system is not structured to allow care to be easily coordinated.

Currently, we have a system of isolated silos. Patients receive care in a variety of settings – doctors' offices, hospitals, nursing homes, etc. – and it's not uncommon for a healthcare provider to have an incomplete picture of a patient's overall care.

In addition, provider incentives created by potential malpractice liability and patient incentives created by insurance choice mechanisms are not well aligned to put the proper focus on better results and lower costs.

We can certainly continue to tinker around the edges of delivering care in new ways, but providers continue to tell me that fear of lawsuits still drives the volume of services. And, of course, our fee-for-service system provides little financial incentive to manage care properly.

When talking about delivery system reform, our goal should be to ensure that patients receive the right care, in the right place, at the right time. There is an appropriate role for both the private payers and the federal government to put pressure on providers to reduce costs and provide better care and better health outcomes.

Now, I know that Rome wasn't built in a day and big changes will take time, but I think we have to move beyond simply reporting what providers are doing to holding them more accountable for health care outcomes. In my own state of Utah, we are privileged to have some of the best, most efficient health care providers in the country. But not all providers are created equal. Much of our healthcare system is fragmented and often the right hand doesn't know what the left hand is doing. Unfortunately, the patient is caught in the middle with very little coordinated care.

I am anxious to hear from you, Mr. Blum, about any real progress CMS has made in moving towards greater care coordination. We know that many errors and costs can be avoided when providers focus on care transitions.

Lately, there has been a lot of attention paid to the flourish of activity coming from Center for Medicare and Medicaid Innovation, also known as CMMI. Like many of my colleagues, I remain concerned that CMMI has an enormous budget and very little accountability. I am hopeful that we'll hold another hearing this spring that focuses exclusively on CMMI and the results of the \$10 billion in taxpayer money that was given to them to advance the cause of higher quality, lower costs, and more efficient care.

And so, Senator Baucus, thank you for convening this hearing today and I look forward to hearing from Mr. Blum. I am hopeful that he will have some good news to share with us on the progress CMS is making to help bend down the cost curve.

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COMMUNICATIONS



NATIONAL ASSOCIATION OF
CHAIN DRUG STORES

Statement
Of
The National Association of Chain Drug Stores
For
U.S. Senate
Finance Committee

Hearing on:

Delivery System Reform: Progress Report from CMS

February 28, 2013
10:30 a.m.
215 Dirksen Senate Office Building

National Association of Chain Drug Stores (NACDS)
1776 Wilson Blvd., Suite 200
Arlington, VA 22209
703-549-3001
www.nacds.org

The National Association of Chain Drug Stores (NACDS) thanks the Members of the Finance Committee for consideration of our statement for the hearing on “Delivery System Reform: Progress Report from CMS.” NACDS and the chain pharmacy industry are committed to partnering with Congress, the Centers for Medicare & Medicaid Services, patients, and other healthcare providers to improve the quality and affordability of healthcare services.

NACDS represents traditional drug stores, supermarkets, and mass merchants with pharmacies – from regional chains with four stores to national companies. Chains operate more than 41,000 pharmacies and employ more than 3.8 million employees, including 132,000 pharmacists. They fill over 2.7 billion prescriptions annually, which is more than 72 percent of annual prescriptions in the United States. The majority of Medicare Part D and Medicaid prescriptions are dispensed by chain pharmacies.

As the face of neighborhood healthcare, community pharmacies and pharmacists provide access to prescription medications and over the counter products, as well as cost-effective health services such as immunizations and disease screenings. Through personal interactions with patients, face-to-face consultations and convenient access to preventive care services, local pharmacists are helping to shape the healthcare delivery system of tomorrow – in partnership with doctors, nurses and others.

In recent years retail community pharmacies have played an increasingly important role in providing patient care. Activities such as the increased number of health screenings provided by pharmacists help educate patients and give them a better understanding of their health status and potential needs. Pharmacists also provide vital patient care through services such as medication therapy management (MTM) and their expanded role in providing immunizations.

Each year, more than 50,000 adults in the United States die from vaccine-preventable diseases.¹ Studies have shown that pharmacist-provided immunization services increase the overall

¹ Department of Health and Human Services, Fiscal Year 2008. Centers for Disease Control and Prevention. *Justification of Estimates for Appropriation Committees*.

immunization rates. Reports have also shown that states allowing pharmacist immunizations have a greater percentage of patients 65 and older who were vaccinated. Immunizations, including those administered by pharmacists, help prevent 14 million cases of disease and 33,000 deaths every year.² Overall, in 2010-11, 18.4 percent of adults received their influenza vaccine at their local supermarket or pharmacy, second only to a doctor's office.³

Notably, the Centers for Disease Control and Prevention (CDC) reports that vaccines have reduced or eliminated many infectious diseases that once routinely killed or harmed thousands each year; according to data collected by CDC, pharmacists have been instrumental in increasing the vaccination rate in the United States. In fact, the CDC has specifically asked the pharmacy community for their continued support and efforts to help address vaccine needs in their local communities.⁴ This is especially vital in rural, and some suburban areas, with limited physician access.

Expanding pharmacists' vaccination authority can also lead to decreased healthcare costs for consumers, health insurers and other third party payors, including Medicare and Medicaid. As noted by the Department of Defense in a 2011 final rule expanding the portfolio of vaccines that TRICARE beneficiaries may obtain from community pharmacies, significant savings were achieved under the TRICARE program when the program was first implemented to allow beneficiaries to obtain flu & pneumococcal vaccines from retail pharmacies. It was estimated that for the first six months that beneficiaries could obtain their vaccinations from pharmacists, 18,361 vaccines for H1N1, flu & pneumococcal were administered at a cost of nearly \$300,000; had those vaccines been administered under the medical benefit, the cost to TRICARE would have been \$1.8M.⁵ Clearly this represents significant healthcare savings, which one would expect to be amplified and replicated if pharmacists were allowed under state laws to provide a broader portfolio of vaccines and/or immunize a broader patient population. (This would be on

² Field RI. Pharmacists set to become more active clinicians in Pennsylvania. *P & T*. 2006;31:100,105; Jelesiewicz E. Pennsylvania pharmacists could soon be "calling the shots." *Temple Times* (online edition). March 17, 2005.

³ Centers for Disease Control and Prevention. Place of Influenza Vaccination Among Adults, United States, 2010-11 Influenza Season, *Morbidity and Mortality Weekly Report*, June 17, 2011, 60(23); 781-785

⁴ Letter from the Centers for Disease Control and Prevention to Pharmacists and Community Vaccinators dated 26 June 2012

⁵ 76 FR 41063-41065.

top of savings that would result from fewer hospitalizations and lost days at work due to more patients obtaining immunizations.) Indeed, this is why the Department of Defense opted to expand the types of vaccines that TRICARE beneficiaries may obtain from community pharmacies to include all CDC-recommended vaccines.

Similarly, policymakers have begun to recognize the vital role that local pharmacists can play in improving medication adherence. The role of appropriate medication use in lowering healthcare costs was recently acknowledged by the Congressional Budget Office (CBO). The CBO revised its methodology for scoring proposals related to Medicare Part D and found that for each one percent increase in the number of prescriptions filled by beneficiaries there is a corresponding decrease in overall Medicare medical spending. When projected to the entire population, this translates into a savings of \$1.7 billion in overall healthcare costs, or a savings of \$5.76 for every person in the U.S. for every one percent increase in the number of prescriptions filled.

Local pharmacists are uniquely qualified to improve medication adherence through medication therapy management (MTM). Congress recognized the importance of MTM, including it as a required offering in the Medicare Part D program. The experiences of Part D beneficiaries, as well as public and private studies, have confirmed the effectiveness of pharmacist-provided MTM.

A recent report by CMS found that Medicare Part D beneficiaries with congestive heart failure and COPD who were newly enrolled in the Part D MTM program experienced increased medication adherence and discontinuation of high-risk medications. The report also found that monthly prescription drug costs for these beneficiaries were lowered by approximately \$4 to \$6 per month and that they had nearly \$400 to \$500 lower overall hospitalization costs than those who did not participate in the Part D MTM program.

How and where MTM services are provided also impacts effectiveness. A study published in the January 2012 edition of *Health Affairs* identified the key role of retail pharmacies in providing MTM services. The study found that a pharmacy-based intervention program increased patient adherence for patients with diabetes and that the benefits were greater for those who received

counseling in a retail, face-to-face setting as opposed to a phone call from a mail order pharmacist. The study suggested that interventions such as in-person, face-to-face interaction between the retail pharmacist and the patient contributed to improved behavior with a return on investment of 3 to 1.

Despite the proven effectiveness of pharmacists in delivering preventive services such as immunizations and MTM, limitations remain in place that prevent pharmacists from practicing to the maximum of their capabilities. These limitations have prevented local retail pharmacists from participating in the various new innovative programs that are being supported by the Center for Medicare and Medication Innovation (Innovation Center). These include the new Accountable Care Organization Models, community-based transitions of care, and bundled payment initiatives.

We believe the Innovation Center should use its authority under section 1115A(d) of the Social Security Act to expand the role of pharmacists in these programs. Unfortunately, we understand that some of the governing bodies of these new models indicate they cannot include pharmacists because the statute does not allow pharmacist to be part of the governance structure or because current Medicare law does not recognize pharmacists as providers. Because of this lack of provider status, pharmacists have been limited in their participation in Innovation Center activities.

Permitting pharmacists to practice to their maximum capabilities within these new delivery models would help increase medication adherence and coordination between healthcare settings, result in higher rates of vaccinations, and reduce the burden of the physician shortage, particularly with the influx of new patients in 2014 through the Healthcare Marketplaces and the expansion of Medicaid eligibility.

In establishing the Innovation Center, section 1115A(d) of the Social Security Act grants the Secretary the authority to waive such requirements of Title XVII as may be necessary for carrying out the testing of innovative models of care. This especially relates to projects that

address populations for which there are deficits in care leading to poor clinical outcomes and potentially avoidable expenditures.

Since pharmacists have the proven ability to provide services that lead to better clinical outcomes and lower healthcare costs, we urge the Innovation Center to use its authority to find mechanisms for pharmacists to participate in these programs, such as granting pharmacists provider status for the purpose of participating in Innovation Center projects.

As we move forward with the reform of the healthcare delivery system, it is imperative for all healthcare providers to practice to their maximum capabilities, working in partnership to provide accessible, high quality care to patients.

Thank you for the opportunity to share our views. We look forward to continuing to work with the committee to advance policies that improve care for Medicare and Medicaid beneficiaries.



Andrea L. Devost, MSN, MBA, RN
Chairman of the Board

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
258 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-5940 fax

Va J. Hifamada, JD
President

STATEMENT FOR THE RECORD

SUBMITTED BY THE
NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
TO THE
SENATE COMMITTEE ON FINANCE
HEARING ON
“DELIVERY SYSTEM REFORM: PROGRESS REPORT FROM CMS”
FEBRUARY 28, 2013

The National Association for Home Care & Hospice (NAHC) is the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies, and public corporations. NAHC has worked constructively and productively with Congress and the regulators for three decades, offering useful solutions to strengthen the home health and hospice programs.

As the Finance Committee examines delivery system reforms in Medicare, NAHC appreciates this opportunity to provide our views. We believe that it is important to ensure home care and hospice participation in transitions in care, accountable care organizations, chronic care management, health information exchanges, and other health care delivery system reforms. We submit the following issue brief for your consideration:

ISSUE: The Patient Protection and Affordable Care Act of 2010 (PPACA) includes significant health care delivery system reforms in addition to expansion of Medicaid eligibility, health insurance reforms, and Medicare payment changes. These health care delivery reforms have the potential to radically alter how and where patients receive care. Overall, these reforms shift the focus of care from inpatient services and institutional care to the community setting. Further, these reforms provide a combination of incentives to clinically maintain patients in their own homes and penalties for excessive re-hospitalizations of patients. Importantly, these reforms also focus on individuals with chronic illnesses, providing support for health care that prevents acute exacerbations of their conditions and avoids both initial and repeat hospitalizations.

PPACA includes, among other health care reforms, new benefits, payment changes, pilot programs and demonstration projects such as Accountable Care Organizations, Transitions in Care penalties for re-hospitalizations, a Community Care Management benefit, and trials of integrated and bundled payment for post-acute care.

Home care and hospice services offer an opportunity for these new programs to work at their highest potential for efficiency and effectiveness of care. Home care and hospice bring decades of experience in managing chronically ill individuals with a community-based care approach, limiting the need for inpatient care and creating a comprehensive alternative to most institutional care.

If these health care delivery reforms are to fully succeed, the Centers for Medicare and Medicaid Services (CMS) must recognize the value of home care and hospice as part of the solution to out-of-control health care spending, particularly for patients with chronic illnesses. CMS should take all possible steps to ensure that any pilot programs or demonstration projects include home care and hospice as active participants and, where appropriate, as the qualified, controlling entity to manage post-acute care and patients with chronic illnesses.

RECOMMENDATIONS: Congressional reforms of the health care delivery system recognize home care and hospice as key partners in securing high quality care in an efficient and efficacious manner. Congress should monitor closely CMS's implementation of the health care delivery reform provisions in PPACA to ensure that the intended goals are fully met. Congress should encourage CMS to look to home care and hospice as part of the solution to rising health care spending in Medicare and Medicaid, including through community based chronic care management. Congress should investigate and remove any existing laws and regulations that create barriers to the inclusion of home care and hospice entities as integrated partners or participants with other health care organizations in transitions in care actions, bundling of payments, or other delivery of care innovations.

RATIONALE: Community-based care is a valuable, but under-utilized health care asset with respect to efforts to reduce hospitalizations and re-hospitalizations. Further, community-based chronic care management has long been provided effectively by home health agencies and hospices. However, the antiquated structure of Medicare benefits has prevented its application at full capacity. The reforms in PPACA present the opportunity to build a new care delivery model that is not handicapped by this out-of-date structure and to overcome longstanding weaknesses in health care delivery.



**United States Senate Committee on Finance
Hearing on "Delivery System Reform: Progress Report from CMS"
February 28th, 2012
Statement for the Record**

Submitted by: National Transitions of Care Coalition, Executive Director Cheri Lattimer

Chairman Baucus, Ranking Member Hatch, and other Members of the Committee, we thank you for holding this important hearing and appreciate the opportunity to submit a statement for the record. The National Transitions of Care Coalition (NTOCC) believes that as policymakers and health care providers strive to improve health care quality and patient safety, it is essential that the improvement of care transitions in our health care system is made a top priority.

The National Transitions of Care Coalition (NTOCC) is a non-profit organization of leading multidisciplinary health care organizations and stakeholders dedicated to providing solutions that improve the quality of health care through stronger collaboration between providers, patients, and family caregivers. The organization was formed in 2006 to raise awareness about the importance of transitions in improving health care quality, reducing medication errors, and enhancing clinical outcomes among health care professionals, government leaders, patients, and family caregivers.

As you are aware, patients —particularly the elderly and individuals with chronic or serious illnesses—face significant challenges when moving from one care setting to another within our fragmented health care system. Poor communication during transitions from one care setting to another can lead to confusion about the patient's condition and appropriate care, duplicative tests, inconsistent patient monitoring, medication errors, delays in diagnosis and lack of follow through on referrals. These failures create serious patient safety, quality of care, and health outcome concerns.

The problems resulting from poor transitions also lead to significant financial burdens for patients, payers, and taxpayers. For instance, unnecessary hospital readmissions are often a result from errors and poor communication made in transitioning patients. Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over \$26 billion every year, with an estimated \$12 billion spent on preventable readmissions.¹ The Medicare Payment Advisory Commission (MedPAC) concluded in its 2009 Report to Congress that a large proportion of re-hospitalizations could be prevented by improving the discharge planning process and coordinating care after discharge.² In fact, several evidenced models focused on improving care coordination have reduced 30-day readmission rates by 20-40 percent.³ Recently in January, the Journal of the American Medical Association (JAMA) published numerous studies and articles around the theme of hospital readmissions and care coordination, and several of those studies suggest that systems focused specifically on transitions of care improve hospital readmissions dramatically.⁴

NTOCC strongly supports several of the current Centers for Medicare & Medicaid (CMS) demonstration programs that are focused on addressing gaps in transitions, particularly for patient populations that are at high risk for a poor transition. This includes the Community Based Care Transitions Program (section 3026 of the Affordable Care Act), which provides funding to test models for improving care transitions for high risk Medicare patients by using services to manage patients' transitions effectively. Now with 102 sites participating in the demonstration across the country, the program will provide care transition services to nearly 700,000 Medicare beneficiaries in 40 states across the country. In addition, other

delivery reforms, such as the Medicare Shared Savings Program, have prioritized key activities, including team-based care, shared decision making, and development of a care plan, which are essential to effective care transitions. We echo Chairman Baucus' emphasis during the hearing on obtaining timely interim results from these demonstrations, and we encourage CMS to share data and results of these demonstrations as they become available so that highly effective strategies can be deployed in other care settings.

Additionally, NTOCC is encouraged by the focus on quality measures in payment programs which rewards activities that seek to address some of the failures that occur during transitions, such as the communication of clear and accurate information between providers, patients, and family caregivers. For example, last year, CMS issued the Hospital Inpatient Quality Reporting Program final rule, and the "3-Item Care Transitions Measure" was incorporated into the existing Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The CTM-3 measure identifies the care processes—"understanding one's self care in the post hospital setting, medication management, and having one's preferences incorporated into the care plan"—that are critical to improving transitions and reducing avoidable hospital readmissions.^v The inclusion of this measure will help hospitals and providers assess whether they are adequately preparing patients to leave the hospital and identify areas for improvement. Most importantly, it necessitates hospitals to adopt a patient-centered approach to transitional care. NTOCC strongly supports the inclusion of this measure for patients in the hospital, and encourages CMS to promulgate the measure in other care settings.

NTOCC believes that quality measures play a very important role in delivery reform. However, it is important that CMS work with pertinent stakeholders to ensure that there is a coordinated effort to reduce any financial or administrative burden that any new quality measures or requirements would pose on healthcare providers. The demands on primary care physicians and hospitals are likely to significantly increase while the Affordable Care Act is implemented, as more individuals will seek preventative care due to requirements that insurance companies must cover these services and almost 30 million individuals will become newly insured. Therefore, NTOCC encourages CMS to seek a balance between additional quality requirements on providers and what is necessary to encourage broader use of best practices and strategies for effective care transitions.

NTOCC believes that the transitions of care process should be a collaborative one that engages the beneficiary, family caregivers, and the entire care team. Case managers, nurses, pharmacists, social workers, and other medical providers play an integral role assisting with patient communication and information transfers. Furthermore, they can aid patients by providing support, advocacy, medication adherence assessment, motivational intervention, resource coordination, enhanced patient self-management, and care planning. NTOCC strongly supports the integrated care and team-based care models that many of the CMS demonstration programs are testing. Additionally, in order to promote shared accountability throughout the transition and among the care-team, NTOCC strongly recommends implementing process measures that are aligned between both the provider (or facility) sending and the provider (or facility) receiving the patient to ensure that key information received has been acted upon.

In addition, people with multiple chronic medical and mental health conditions are among the highest-risk patients most prone to harm from inadequate transitions. According to the American Hospital Association, "Research indicates that better integration of behavioral health care services into the broader health care continuum can have a positive impact on quality, costs and outcomes."^{vi} NTOCC encourages CMS to continue to work towards incentivizing a more integrated care system which takes mental and behavioral health circumstances into account for higher quality, more streamlined care.

NTOCC supports the many provisions in the Affordable Care Act that are aimed at promoting care coordination and effective transitions, but believes that more can be done, and we encourage the Committee to consider more fundamental payment changes that target care transitions. In fact, MedPAC's June 2012 Report to Congress specifically highlighted that "given the evidence on transitional care to date, an established payment could be made to a care manager who would work with the beneficiaries during their hospitalization and as they move to the community or other setting."^{vii}

With that in mind, last year, Congressmen Earl Blumenauer (D-OR) and Thomas Petri (R-WI) introduced the Medicare Transitional Care Act, which would provide Medicare beneficiaries that are at highest risk for hospital readmissions access to evidence-based transitional care services provided by an eligible transitional care entity, such as a hospital or skilled nursing facility. Payment for these services would be linked to performance metrics to ensure that interventions result in improved outcomes, which will ultimately lead to reductions in Medicare spending.

The transitional services defined in the bill align with NTOCC's "Seven Essential Intervention Categories" which highlights the essential care transition interventions identified from a cross-walk of the various models of care, such as the Care Transitions Intervention, Transitional Care Model, Guided Care Model, Project Re-Engineered Discharge and Better Outcomes for Older Adults through Safe Transitions, and Rush University Medical Center's Enhanced Discharge Planning Program, all of which have demonstrated improvements in both health outcomes and reduction in costs to the health care system. The legislation would foster the use of these and other evidence-based transitions of care models.

We encourage the committee to consider similar care-transitions-focused proposals going forward which will build on the progress made in the ACA, address the current gaps in care coordination, improve patient outcomes, and reduce unnecessary health related expenses both for struggling families and for Medicare.

NTOCC appreciates the opportunity to submit a statement for the record and looks forward to working with the Committee to strengthen our health care delivery system.

ⁱ The Community Based Care Transitions Program: The Centers for Medicare & Medicaid Innovation. Web. Center <http://innovation.cms.gov/initiatives/CCTP/>

ⁱⁱ Medicare Payment Advisory Commission. Report to Congress: Improving Incentives in the Medicare Program. June 2009. Web. http://www.medpac.gov/documents/jun09_entirereport.pdf

ⁱⁱⁱ Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates, Proposed Rule, Fed. Reg. Vol. 77, No. 92. 28110-28039 (May 11, 2012). Web. <http://www.gpo.gov/fdsys/pkg/FR-2012-05-11/html/2012-9985.htm>

^{iv} Journal of the American Medical Association. Vol. 309.4 (2013): Print.

<http://jama.jamanetwork.com/issue.aspx?journalid=67&issueid=926266&direction=P>

^v Coleman, Eric, MD, MPH. "3 Item Care Transitions Measure- FAQ." The Care Transitions Program. The Care Transitions Program, 12 June 2012. Web. 13 Jun 2012. http://www.caretransitions.org/documents/CTM_FAQs.pdf

^{vi} "Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes." Trend Watch. American Hospital Association, n.d. Web. 11 Mar 2013.

http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CDIQIAAJ&url=http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf&ei=JyY-Uaq1EIn20gHS4IGQDg&usq=AFOICNGm1aGy2-3M_oTvBON7i66Jz2IEUw&sig2=gPrXrXW7Ji36uHY28XVUQ&bvm=bv.43287494.d.dmQ

^{vii} Medicare Payment Advisory Commission. Report to Congress: Medicare and the Health Care Delivery System. June 2012. Web. http://www.medpac.gov/documents/jun12_EntireReport.pdf



Statement for the Record

Submitted by

The Premier healthcare alliance

Senate Finance Committee

“Delivery System Reform: Progress Report from CMS”

February 28, 2013

The Premier healthcare alliance appreciates the opportunity to provide a statement for the record of the Senate Finance Committee hearing, entitled “*Delivery System Reform: Progress Report from CMS*.” Premier is a performance improvement alliance of more than 2,700 U.S. hospitals and 90,000 other sites using the power of collaboration and technology to lead the transformation to coordinated, high-quality, cost-effective care.

We applaud the leadership of Chairman Baucus and Ranking Member Hatch for holding this important hearing. Members of the Premier healthcare alliance have been strong and consistent supporters of delivery system and payment reforms and are encouraged by efforts to ensure their successful, bipartisan implementation. While there are many initiatives our alliance members can undertake on their own to improve the quality, safety and affordability of healthcare, continued government action is needed to fix perverse payment incentives.

Members of the Premier alliance are working with the federal government and a variety of payors and populations in order to create a more coordinated, efficient healthcare system. These organizations are actively working to put in place advanced processes and infrastructure to assume risk for the quality and outcomes of care, including the Medicare population, commercial markets, self-funded employers, provider-sponsored plans and Medicaid. With new incentives in place, and programs such as the Medicare Shared Savings Program and the Bundled Payment Care Improvement initiative, our healthcare system will have greater flexibility and the ability to innovate to improve the health of communities.

In fact, collaboratives that are spearheaded by our alliance and centered around delivery system reforms are already showing impressive results in improving the quality of care received by patients and are reducing costs. These include:

- **Premier's QUEST: High Performing Hospitals** is a nationwide collaborative with more than 336 hospitals across the country working together to set national standards for excellence and quality. Together, these hospitals are developing the roadmap for setting and achieving aggressive performance targets in the areas of cost of care, evidence-based care, mortality, harm avoidance, readmissions and patient satisfaction. Over QUEST's first four years, participants reduced healthcare spending by nearly \$9.13 billion, and prevented 91,840 inpatient deaths.

- **The Partnership for Care Transformation (PACT)** is a collaborative of more than 90 health systems working to evaluate and build accountable care organization (ACO) capabilities through education, best practice sharing and measurement/benchmarking. PACT is divided into two groups: Implementation and Readiness. Implementation participants are actively implementing an ACO, either with CMS or in the private market. Readiness organizations are learning about accountable care, and evaluating how to implement an ACO or accountable principles in their health systems.
- **Premier's Bundled Payment Collaborative** is designed to help health systems develop, implement and succeed in bundled payment arrangements in both public and private markets. More than 50 hospitals across 18 states have joined the program, which provides ongoing analysis, assessment, technical assistance, education and knowledge sharing to successfully address issues providers will encounter while implementing bundled payment and redesigning care delivery. Premier's Bundled Payment Collaborative is currently focused on model 2 of the Center for Medicare & Medicaid Innovation's Bundled Payments for Care Improvement Initiative, which includes hospital and post-acute care services.
- **The Partnership for Patients**, launched in April 2011, is a nationwide public-private partnership that offers support to physicians, nurses and other clinicians working in and out of hospitals to make patient care safer and to support effective transitions of patients from hospitals to other settings. Participants focus on reducing preventable readmissions to hospitals by 20 percent and reducing preventable hospital-acquired conditions by 40 percent by the end of 2013. With more than 450 hospitals participating, Premier is the second largest of 26 Hospital Engagement Networks approved by CMS to participate in the initiative.

Premier urges the Congress to take advantage of these and other healthcare providers' efforts to transform our healthcare system to provide better quality and value into the future by accelerating and strengthening payment and delivery system reforms. The current fee-for-service payment system is misaligned with healthcare provider's attempts to achieve coordinated and cost-effective healthcare. It is critical that new delivery system models give providers levers to step away from our broken fee-for-service system toward alternatives that can reward quality and cost effective care. Specifically, we urge Congress to:

- **Support bundled payment:** A single payment rate for an episode of care that spans the continuum of care has great potential to better coordinate and streamline patient care and inspire innovation. The idea behind this is to pay a blanket payment for hip replacement or structure the system so providers view the episode as a whole, which incents providers to work together to better manage care. Currently these episodes involve many separate billable procedures across different types of providers and payment silos.
- **Strengthen value-based purchasing:** While VBP exists and is working for hospitals, it remains a ways off for the other payment silos. Premier urges Congress to accelerate value-based purchasing in post-acute care sites.
- **Expand and adjust payment reforms to preserve access to quality care:** ACOs and bundling may not be feasible in remote areas, and may face challenges in low-income areas. Premier urges Congress to consider what other changes in policy are needed to incent value, but preserve access to care.
- **Replace the Sustainable Growth Rate:** Payments under the Medicare Physician Fee Schedule will be cut by nearly 30 percent January 1, 2014 without intervention by Congress. The cuts have grown so large that letting them go into effect would be detrimental to patient access to physician care. Premier urges Congress to act now to restructure the system.

While new models of payment and care are helping hospitals and other providers transform the way care is delivered, regulatory barriers still exist in the current healthcare system that limit the extent to which hospitals and other providers are able to improve the quality, efficiency and accessibility of the healthcare they deliver. We still need to eliminate obstacles such as some of those that exist in the self-referral and antitrust provisions that prevent physicians and hospitals from integrating their services.

With sustained diligence and oversight by Congress to bolster bipartisan delivery system reforms, we are confident that hospitals and other healthcare providers will continue on the path toward higher quality care while bending the cost curve.



MARY KAY HENRY
International President

ELISEO MEDINA
International Secretary-Treasurer

KIRK ADAMS
Executive Vice President

MICHAEL P. FISHMAN
Executive Vice President

GERRY HUDSON
Executive Vice President

EILEEN KIRLIN
Executive Vice President

VALARIE LONG
Executive Vice President

TOM WOODRUFF
Executive Vice President

SERVICE EMPLOYEES
INTERNATIONAL UNION
CTW, CLC

1800 Massachusetts Ave, NW
Washington, DC 20036

202.730.7000
TDD: 202.730.7481
www.SEIU.org

Statement of Kirk Adams
International Executive Vice President,
Service Employees International Union

United States Senate Committee on Finance
“Delivery System Reform: Progress Report from CMS”
Thursday, February 28, 2013

Thank you Chairman Baucus, Ranking Member Hatch, and members of the Committee for holding this important hearing on our healthcare delivery system.

As the largest healthcare union in the nation, representing more than 1.1 million workers in the healthcare sector, the Service Employees International Union (SEIU) is strongly invested in the modernization of the U.S. healthcare system. The initial delivery system reforms implemented by the Center for Medicare and Medicaid Services (CMS) establishes CMS as the leader for instituting payment and care policies that promote higher quality and more efficient healthcare.

While many have focused on the important ways the Affordable Care Act (ACA) improved access to affordable healthcare coverage, delivery system reforms included in the ACA are just as groundbreaking. Generally, under Medicare and Medicaid, providers are paid per service and there is little incentive for providers to work together across settings, resulting in fragmented and unnecessary care. This breakdown is especially apparent when examining those that suffer from multiple chronic conditions who are more likely to have preventable hospitalizations and account for a disproportionate share of healthcare spending.¹

However, new demonstrations seek to change this reality. For example, a growing number of providers are on course to participate in one of the Accountable Care Organizations (ACO) demonstrations currently underway. ACOs are groups of doctors, hospitals and other providers that work together across care settings to coordinate care for Medicare patients. If an ACO is able to meet specified healthcare quality measures and while meeting these achievement thresholds are able to lower costs, the ACO may share in savings achieved to the Medicare program. These new models create incentives to ensure patients get the care they need when they need it—appropriate follow up care after release from a hospital, for example, that will prevent the need for rehospitalization—while preventing duplications in care or providing unnecessary care.

The ACA also established the Medicare and Medicaid Coordination Office (MMCO), charged with improving and better integrating coverage

and care for those who are eligible for both Medicare and Medicaid. Currently, MMCO is working with states and stakeholders on several initiatives. These include a financial alignment demonstration, which will align payment policies between Medicaid and Medicare to help facilitate better care coordination, as well as a program to prevent unnecessary hospitalizations among nursing home patients.

The CMS Center for Medicare and Medicaid Innovations (CMMI), the agency within CMS managing many of these reforms, received almost 3,000 applications for the Healthcare Innovations Award program. The Healthcare Innovations Awards supplied grants for pioneering models of service delivery that result in better care, better health and lower costs through improved quality. Integral to the award of these funds are models that incorporate healthcare workforce training and deployment in support of these delivery system innovations. SEIU United Long Term Care Workers and SEIU United Healthcare Workers West along with several public and private partners are proud to be participating in an effort through this program to improve patient-centered long term care by training and enhancing the role of personal and home care attendants (PHCAs) to provide vital prevention and intervention activities for patients. These reforms, among others, aim to bend the cost curve not just in Medicare and Medicaid, but across the entire healthcare sector, the root cause of rising costs in both programs.

There is reason to be optimistic that reforms will have a tangible affect. Recently, the Congressional Budget Office announced that Medicare and Medicaid program spending will be \$382 billion lower from 2013 – 2022 than the projections the agency released in August 2012.ⁱⁱ While a number of factors may affect the significantly lower than projected growth rate of the programs, policy experts indicated that structural changes to the healthcare system likely contributed.ⁱⁱⁱ

However, despite some indications the healthcare sector is changing, it is important to understand that change takes time and patience is necessary. Programs and demonstrations are still in their infancy and expecting too much too soon could put the success of these programs and the progress already made at risk. While hard data may still be forthcoming, the cultural shift and growing interest in reforms from all stakeholders is palpable. Participation in programs and demonstrations are high. According to CMMI's 2012 Report to Congress, "The result [of stakeholder engagement] is a growing portfolio of innovative service delivery model tests, with the support and participation of over 50,000 healthcare providers, over 3,700 hospitals, and Medicare, Medicaid and CHIP beneficiaries nationwide."^{iv}

We are hopeful that delivery system reforms over time will continue to increase quality and efficiency in healthcare and the long-term gains will exceed even current expectations. But to make this a reality, upfront investments made now are critical to ensuring success in the future. These investments include equipping our nation's healthcare workforce with training, skills and knowledge necessary help institute changes. Over the next decade, employment in the healthcare sector will continue to grow rapidly, primarily driven by significant increases in demand for healthcare as a result of new access to coverage. Also, projected retirements for current healthcare workers will necessitate a pipeline of skilled individuals ready to enter healthcare occupations. Changes to healthcare delivery and practice through system reform and a growing population in need of care will drive the creation of new job categories, the possibility for

increased responsibility and differing roles for the existing health workforce, and the need for expanded training capacity. For example, given the growing roles of nurses, nursing shortages must be addressed by expanding educational pipelines. Currently, there are an insufficient number of registered nursing education slots and the lack of infrastructure, such as clinical sites and lab spaces, prevent programs from increasing enrollment. Furthermore, there are limited opportunities for working adults seeking part-time, evening and weekend professional training.

In addition, to achieve true care coordination, an essential element of many delivery system reform demonstrations underway, we must also invest in the paraprofessional workforce. Paraprofessionals will play an increasingly important role in providing care to patients. Direct care workers, especially those who care for seniors and those with disabilities in their homes, could receive training to meet new demand for primary and preventive care. For example, personal care aides who care for the elderly and disabled could educate patients about nutrition and perform other home-based medical tasks; such as taking blood pressure readings. This will help forge the link between primary and long term care and to facilitate the reorientation of healthcare toward wellness and primary care, a goal of transforming delivery systems. For this reason, it is imperative that home care providers are incorporated into care teams. Furthermore, the development of the home care workforce is essential to providing community-based long term care services and supports, which is not only cost effective but also allows individuals to receive care in the setting of their choosing, improving patient experience.

There is great potential in these reforms and it is imperative we continue to provide the support and time necessary for programs and models to take effect. Delivery system reforms provide a unique promise; that we can promote the fiscal health of Medicare and Medicaid, while improving care quality and maintaining access to and the affordability of healthcare coverage.

Thank you for the opportunity to testify before the Committee.

¹ The Robert Wood Johnson Foundation and the Johns Hopkins Bloomberg School for Public Health, *Chronic Care: Making the Case for Ongoing Care* (February 2010). Available at <http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf54583>.

² Doug Elmendorf, Congressional Budget Office, *How Have CBO's Projections of Spending for Medicare and Medicaid Changed Since the August 2012 Baseline* (February 2013). Available at <http://www.cbo.gov/publication/43947>.

³ Annie Lowrey, *The New York Times*, "Slower Growth of Health Costs Eases Budget Deficit" (February 2013). Available at <http://www.nytimes.com/2013/02/12/us/politics/sharp-slowdown-in-us-health-care-costs.html>.

⁴ Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation, *Report to Congress* (December 2012). Available at <http://innovation.cms.gov/Files/reports/RTC-12-2012.pdf>.

